Community-Based Services
Quality Assurance/Quality Improvement

The Division of Developmental Disabilities is statutorily responsible to ensure maximum quality of services are provided to people with developmental disabilities throughout the state. The Division has implemented standards to ensure quality services through Title 404 of the Nebraska Administrative Code, and it is also responsible to comply with the stringent terms and assurances required by the Centers for Medicare and Medicaid in Nebraska's Home and Community Based Developmental Disability Waivers (HCBS Waivers). This is primarily accomplished through the Division's Quality Assurance/Quality Improvement section.

The Division's Quality Assurance/Quality Improvement Section is led by Kathie Lueke and is comprised of three areas: Waiver Management, Survey and Certification, and Technical Assistance.

Waiver Management

Pam Hovis is the Division's Waiver Manager, and her team consists of two staff assistants, a contract coordinator, and twelve developmental disability services specialists (DSSs) that are physically located in local offices throughout the state. Pam has worked in the field of developmental disabilities for almost twenty-five years. With minimal technical assistance provided by the Centers for Medicare and Medicaid Services, she was able to craft Nebraska's current HCBS Waivers that meet, and in many ways exceed, national standards for person-centered practices and that emphasize true community integration and employment opportunities. In the past year, she has also taken over management of the DSSs (which were recently managed by DD Service Coordination Districts, and prior to 2009 were under the Division of Children and Family Services), and provided them with significant training and oversight to equip them with the skills necessary to ensure compliance with CMS's increasing quality assurance requirements.

The Waiver Management team has also recently taken over responsibility for developmental disability eligibility determinations. This change was made to realign duties related to service coordination, and to ensure accuracy and consistency of eligibility determinations throughout the state. Eligibility determinations are significant for the Division, because our federal funding is contingent on valid and well-documented eligibility determinations. The DSSs have received enhanced training on eligibility requirements and

processes, and they have access to two DD Division staff psychologists when such expertise is required. The Individuals, families and other stakeholders have provided much positive feedback about this realignment of the eligibility process.

Ensuring waiver compliance is crucial to the Division's success, as almost 60% of our funding for developmental disability services is reliant on this compliance. It is also important that the Division continue to meet routinely with individuals, families and community stakeholders to ensure that the service array provided by our current waivers continues to meet the needs of the people we support. The Waiver Management team will lead the effort in ensuring waiver compliance and assessing community needs.

Survey and Certification

The Survey and Certification team is led by Jeremy Youngs. In October 2010, the Division assumed all certification activities for Specialized Providers. The 6 surveyor positions funded by the Legislature for increased community oversight were then transferred to the Division of Developmental Disabilities from the Division of Public Health. The Survey and Certification team is now comprised of 9 surveyors that are located in Lincoln, Omaha, and Hastings. The Surveyors focus on certification activities which include: on-site certification reviews, complaint review and investigations, analysis of reported incidents, and service reviews of provider services.

The Survey and Certification team has been provided with significant training to equip them to address the needs of the people served in the DD system. Labor Relations Alternatives, Inc. has provided them with training in "Conducting Serious Incident Investigations" and every surveyor is required to be certified as a Level I Investigator. The Council on Quality Leadership has trained the team generally on outcome based programming and person-centered practices, and has also provided the team with a four day assessment workshop on evaluation/monitoring of outcome based services. Dr. Michael Neise and Scott Fouts (Paradigm, Inc.) provided the team training on the development and assessment of functional behavior assessment, behavioral support plans, and safety plans. Through H&W Consulting, the team was able to work with Catherine Hayes (a prior branch chief over survey and certification for the Centers for Medicare and Medicaid Services) to develop survey and certification processes and strategies and to receive further training on thorough investigations strategies. The BSDC medical/professional team has also provided training on the identification of particular medical needs and proper medical supports for individuals in a community setting. Future training needs for the team will continue to be assessed annually.

During the 2009 and 2010 Legislative hearings and the Division's stakeholder meetings held across the state, concern regarding quality oversight for community services was a repeated theme. The Division has worked hard to address these concerns and to ensure that individuals, families, and community stakeholders can be confident in the quality of services being provided

by the Division. Statistical data that illustrate the activities of this team are included herein. Much progress has been accomplished in this area, but the Division will remain diligent to ensure consistency in the survey and certification activities.

Technical Assistance

With the assumption of certification activities by the Survey and Certification team, the development of new waiver services, and revision of the Divisions regulations, we recognized the importance of providing technical assistance to community providers separate and apart from the survey process; thus, the Technical Assistance team was created in 2009. The technical assistance team is led by Kim Johnson and consists of two psychologists, one program specialist and two human services treatment specialists. Technical assistance services occur by phone, email, in-person, or via formal meetings or training opportunities.

In addition to general technical assistance, the Technical Assistance team processes and assists with the referrals for Team Behavioral Consultation (TBC), which is a service available to teams working with individuals who are experiencing challenging behaviors. The Division currently has an internal team (formerly the OTS program which was housed at BSDC) and also contracts with OMNI Behavioral Health to provide TBC. From January to December 2010, 127 Team Behavioral Consultations were completed statewide. Up to August 30, 2011, 55 consultations have occurred or are currently in process statewide for the current calendar year. TBC services are assessed on a quarterly basis; statistical data relating to TBC services is included herein.

The Technical Assistance team also prepares, conducts, and/or organizes DDD sponsored trainings statewide. These have consisted of: objective assessment process training; service coordination supervisor IPP review; the quarterly seminar series by Dr. Stull & Dr. Sorrell of BSDC; planning with personal outcomes; eligibility determination training; Scales of Independent Behavior – Revised (SIB-R); and adult protective service reporter training by DHHS Children and Family Services Division. The Technical Assistance team participates in training alongside other Division staff, so that they are equipped to share information and skills gained with providers, individuals in services and their families and other stakeholders. They also make a diligent effort to provide competency tools, record Division training sessions and retain training documentation, so that training materials can be shared with others.

The Technical Assistance team is a key component of ensuring the continuity of quality services across Nebraska. It is not feasible for local providers to have independent access to all areas of expertise in the developmental disability field, and it is quite difficult to stay on top of evolving national best practices. The Technical Assistance team helps bridge this gap for community providers. Being independent from the Survey and Certification team is also helpful, as providers are sometimes hesitant to seek advice from staff that are responsible for regulatory activities.

The Division has been pleased with the progress made by the Technical Assistance team. The team's activities will be reviewed on an annual basis, and ongoing discussions will be held with individuals and their families, providers, and other community stakeholders to assess areas of need.

Performance and Quality Improvement (QI) Plan
Community Based Services
DHHS Developmental Disabilities Division

I. Introduction

A. Organization's Philosophy of QI

The Nebraska DD System initiates self-auditing and self-correcting processes to assure the sustainability of regulatory compliance, and the flexibility to pursue excellence in service to people with developmental disabilities. The performance measures of the Home and Community-Based Services (HCBS) waivers provide a quality framework that focuses on participant-centered desired outcomes addressed through discovery, remediation, and continuous improvement. In addition, requirements and recommendations associated with the DOJ Agreement with Nebraska contribute to this plan.

B. Responsibility for Oversight of QI

The DHHS DDD Quality Improvement efforts for Community Bases Services are coordinated through the DDD QI Committee (QIC) comprised of representatives from DDD Central Office, DHHS Licensure Unit, DHHS Medicaid, and DDD Service Coordination. The Division QI Committee meets on a quarterly basis and reviews aggregate data for statewide monitoring and certification to identify trends and consider statewide changes that will support service improvement. The committee also reviews data and reports on, including but not limited to: HCBS waiver service requirements, incidents, complaints, investigations, certification and review surveys, and related information reported by other DHHS divisions.

As a result of committee review, recommendations for action are submitted to the Community Based Services Administrator. The QIC reviews follow-up on actions which are implemented as a result of recommendations.

C. Outline/Overview of the QI Process

The Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) offers a variety of services and supports intended to allow individuals with intellectual or developmental disabilities (I/DD) to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. A combination of non-specialized and specialized services are offered under the waivers for adults, and children and their families as appropriate, to allow choice and flexibility for individuals to purchase the services and supports that only that person may need or prefer. Non-specialized services to provide support in community living are services directed by the individual or family/advocate and delivered primarily by independent providers. These self-directed, or participant-directed, services are intended to give the individual more control over the type of services received as well as control of the providers of those services. Specialized services are habilitation services that provide residential and day habilitative training and are delivered by contracted certified DD community-based agency providers.

Performance and Quality Improvement (QI) Plan
Community Based Services
DHHS Developmental Disabilities Division

The goals and objectives for community-based services are:

Goals:

- Prevent institutionalization in an ICF or nursing facility for individuals whose needs can be met by community based DD providers.
- Promote a high quality of service delivery in community based services.
- Expand participant direction of services.

Objectives:

- Have a sufficient number of waiver slots each year of the waiver in order to have waiver services available to individuals who meet the eligibility criteria.
- Continue to work with the Division of Medicaid and Long-Term Care (DMLTC), the Division of Public Health (DPH), DDD Service Coordination, and DDD Surveyor/ Consultants, to develop and enhance a statewide quality improvement plan.
- Share and make use of all monitoring data.
- Monitor provider quality assurance activities.

DHHS DDD, the single State Medicaid agency, operates the Home and Community Based Services (HCBS) waivers for adults and children with developmental disabilities. DHHS staff enroll independent providers to deliver non-specialized services and community supports to eligible individuals. DHHS DDD formally certifies DD community based provider agencies and DDD contracts with certified DD provider agencies, to deliver specialized habilitation services. The Division has a formalized review process conducted by designated DDD staff to determine eligibility of individuals for the waivers. An individual's eligibility for waiver services is established on an initial and annual basis.

Desired Outcomes for services through the HCBS waivers are:

- Individuals have access to home and community-based services and supports as an individual choice.
- Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
- There are sufficient HCBS providers that possess and demonstrate the capability to effectively serve individuals receiving community based services.
- Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- Participants receive support to exercise their rights and in accepting personal responsibilities.

The Division's quality assurance efforts include a system to effectively monitor community-based placements and programs with appropriate protections, services, and supports. This is partially accomplished through active monitoring for *individuals* in services through local Service Coordination offices.

Performance and Quality Improvement (QI) Plan
Community Based Services
DHHS Developmental Disabilities Division

In order to assure protections, services, and supports on a *systems* level, the Division has established a formal certification and review process in accordance with state regulations, contract specifications, and state waiver requirements for provider agencies providing specialized services. This certification process includes certification and service reviews of community-based providers and programs by DDD Surveyor/Consultants, which are scheduled in accordance with the initial provisional, 1-year, or 2-year certifications issued by the Division. The purpose of the reviews is to identify gaps and weaknesses, as well as strengths in specialized services provided on a statewide level. In order to ensure continued certification as a provider of DD specialized services, a formal plan of improvement is required to ensure remediation of review findings that need to be addressed. On an ongoing basis, incidents and complaints associated with certified providers which have been reported to the Division are reviewed and appropriate levels of follow-up are conducted.

D. Stakeholders of the Performance and Quality Improvement efforts within the Division are:

External:

Individuals (and when applicable families and guardians) served through the HCBS waivers
Provider organizations and direct support staff
CMS
Legislators
Nebraska taxpayers
Department of Justice

Internal:

DDD staff and Administration
DHHS Divisions and Administration
Governor of Nebraska

II. Measures and Outcomes

A. Long-term Strategic Goals and Objectives

HCBS Desired Outcomes:

- Individuals have access to home and community-based services and supports as an individual choice.
- Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences, and decisions concerning his/her life in the community.
- There are sufficient HCBS providers that possess and demonstrate the capability to effectively serve individuals receiving community based services.
- Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- Participants receive support to exercise their rights and in accepting personal responsibilities.
- Participants are satisfied with their services and achieve desired outcomes.

- The system supports participants efficiently and effectively and constantly strives to improve quality.

DOJ Requirements relating to quality:

- The State shall develop and implement a comprehensive quality assurance program to track and analyze patterns and trends of incidents and injuries, including incidents and injuries of unknown origin. The State shall develop and implement prompt and effective measures to address patterns and trends that impact the health, safety, and welfare of residents, so as to minimize or eliminate their occurrence in the future.
- The State shall place an emphasis on identifying and analyzing resident-to-resident interactions that create risk of harm and/or actual harm, and then develop and implement measures to address these risk factors to prevent residents from harming themselves or others. The State shall identify vulnerable residents who are at higher risk of harm, and develop and implement measures to minimize or eliminate potential risk factors. The State shall identify aggressor residents and develop and implement measures, in conjunction with behavioral and other interventions, to minimize or eliminate potential triggers for aggression.

B. What to Measure

1. Management/Operations Performance

Current HCBS Performance Measures include:

- ✓ Of the total number of DDD QI committee meetings, the total number of meetings in which the Medical Assistance Unit staff participated.
- ✓ The number of new waiver eligibility determinations completed by the disability services specialist within 2 weeks of receipt of all required information.
- ✓ Number of percent of waiver participants who have had an annual Level Of Care (LOC) redetermination within one year of their initial LOC evaluation and within 1 year of their last annual LOC evaluation.
- ✓ Of the total number of LOC determinations, the number of LOC redeterminations that were completed accurately according to the processes and instruments described in the approved waiver and according to the approved description to determine participant level of care.
- ✓ Of the total number of certification/compliance reviews completed on certified providers, the number of providers cited for failure to adhere to required regulations.
- ✓ Of the total number of newly certified providers, the number of providers that initially meet required background checks prior to delivery of waiver services.
- ✓ Of the total number of certified providers, the number of providers that continue to meet all required certification standards.
- ✓ Out of the total number of background checks completed on non-licensed/non-certified providers, the number of background checks completed prior to provider approval.

- ✓ Out of the total number of non-licensed/non-certified independent providers, the number of non-licensed/non-certified independent providers that met initial waiver provider qualifications.
- ✓ Out of the total number of non-licensed/non-certified independent providers, the number of non-licensed/non-certified independent providers that continue to meet waiver provider qualifications.
- ✓ Of the total number of service plans reviewed, the number of plans that have been determined to be written in accordance with identified DDD policies and procedures.
- ✓ Of the total number of service plans, the number of IPPs developed by the team annually and reviewed semi-annually.
- ✓ Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the waiver application.
- ✓ Of the total number of certified provider agencies that employ staff, the number of agencies that have training records for their employees that indicate these staff have met provider training requirements.
- ✓ Of the total number of certification/compliance reviews completed on certified provider agencies, the number of provider agencies that have met training requirements.

2. Program/Service Delivery Effectiveness

Effectiveness shall be measured through dimensions of service quality including: accessibility, availability, efficiency, accuracy, continuity, safety, timeliness, respectfulness and other dimensions as appropriate.

a. Individual Plans

- ✓ Of the total amount of IPP reviews, the number of reviews that indicate medical services are specified and documented on the IPP.
- ✓ Out of the total number of monitorings, at the time of the monitoring, the number of persons free from abuse and neglect.
- ✓ Out of the total number of service coordination monitorings, the number of neglect and abuse allegations that were followed up by the DD provider.
- ✓ Out of the total number of reported incidents of suspected abuse/neglect, the number reported within the required timeframe.
- ✓ Of the total number of service coordination monitorings, the number of monitorings that indicate medical issues are being addressed as documented in the IPP.

b. Participant Experience

- ✓ Number and percent of new waiver participants each year whose records contain an appropriately completed and signed Consent/Request for Services form which offered a choice between institutional and waiver services.
- ✓ The number and percent of new waiver participants or their legal guardian if applicable, that participated in making a choice of waiver providers.

- ✓ Of the total number of individual and family pre-service plan meetings conducted annually, the number of meetings that reflect the waiver participant was afforded choice between/among waiver providers.
- ✓ Out of the total number of monitorings, the number of SC monitorings that indicate the management of services, supports, and providers is occurring as documented in the service plan.
- ✓ Out of the total number of waiver participants, the number of individuals that had no issues with their non-certified community supports provider performance.

2. Client and Program Outcomes
   - ✓ Of the total number of Individual Programs Plans developed each year, the number of plans that were revised due to a change in a person's needs.
   - ✓ Of the total number of IPP reviews, the number of reviews that indicate the authorized units match the state's electronic authorization and billing system.
   - ✓ Of the total number of service plans, the number of plans that reflect services were authorized as specified in the plan.

III. QI Operational Procedures

A. Framework of QI Data Collection Process

PLAN	What is Being Measured?
	Why is it Being Measured?
	What is the Data Source?
	Who is Responsible?
DO	What Will Be Done/How/Frequency?
	How Will Data Be Collected (& by whom)?
	How/Who Will Aggregate the Data and Generate Reports?
	In What Format Will Data Be Reported?
CHECK	Who/When Will Results be Reviewed and Interpreted?
	To Whom Will Recommendations be Made/Timeframes?
ACT	Who Will Implement/Over-See Recommended Changes?

B. Reporting Data

1. Process of Aggregating Data and Monitoring Data Trends

Data is aggregated through queries from systems where data is entered directly by the worker or reporter. These systems include Info Path, SAS, N-FOCUS, Therap, Share Point and OnBase. For data that is not entered directly into a system, data is derived from individual source documents such as audits of files or certification reports, and manually tabulated as necessary.

2. Report Formats

Reports reflect data and information in charts, graphs, tables, and narrative formats. QI Committee minutes display meeting topics and discussion, as well as action plans or follow-up categorized by performance measures.

C. Communicating Results

Aggregate data is shared through the QI Committee with DD Administrative staff, Service Coordination, and other stakeholders. Data reports are submitted as requested to CMS Waiver representatives and the Department of Justice Independent Expert.

D. Using Data for Implementing Improvement

Data is reviewed on at least a quarterly basis through the QI Committee and DD Administration. Appropriate recommendations, action plans, and follow-up are included within the QI Committee minutes.

E. Assessment of the Effectiveness of the QI Process

Contributors to the assessment of the QI process can be determined through CMS audit and onsite visit reports and findings. In addition, effectiveness is also measured through the relevancy that collected dated has in providing useful information on the timeliness and quality of services provided through Community Based Services.

Overview of Critical Incidents Reports – January 2010 through March 2011

Critical Incident Verbal Reports by Time of Day

Time of Day	Jan – Mar '11	Oct – Dec '10	July – Sept '10	Mar – June '10	Time of Day	Jan – Mar '10
6 AM – 8:59 AM	5%	6%	7%	3%		
9 AM – 4:59 PM	74%	74%	69%	63%	7AM -3 PM	52%
5 PM – 10:59 PM	19%	18%	18%	25%	3:01 PM – 11 PM	36%
11 PM – 5:59 AM	1%	2%	3%	9%	11:01 PM – 6:59 AM	4%
No time listed	9%		3%		No time listed	8%

For Reference when reviewing chart by category:

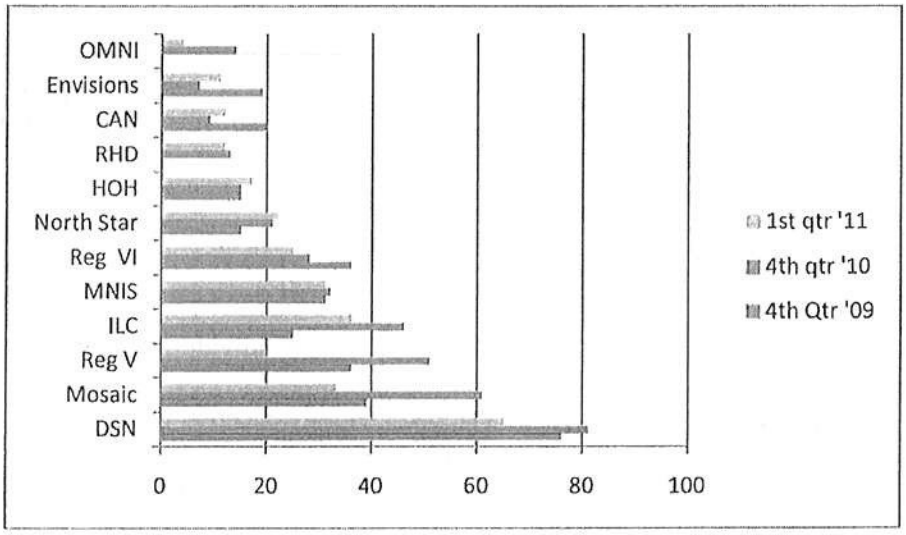
1. Leaving staff supervision where the safety of the individual or others is potentially threatened.
2. Hospitalization due to mental health/behavioral concerns.
3. Injuries which require medical attention (Dr. Office, ER visit, hospitalization) to individuals, staff persons or others with whom the individual comes in contact.
4. Injuries involving restraints.
5. Police contacts due to behavior.
6. Death (of persons served).

2 & 5 Combined. Police contact due to behavior resulting in hospitalization.

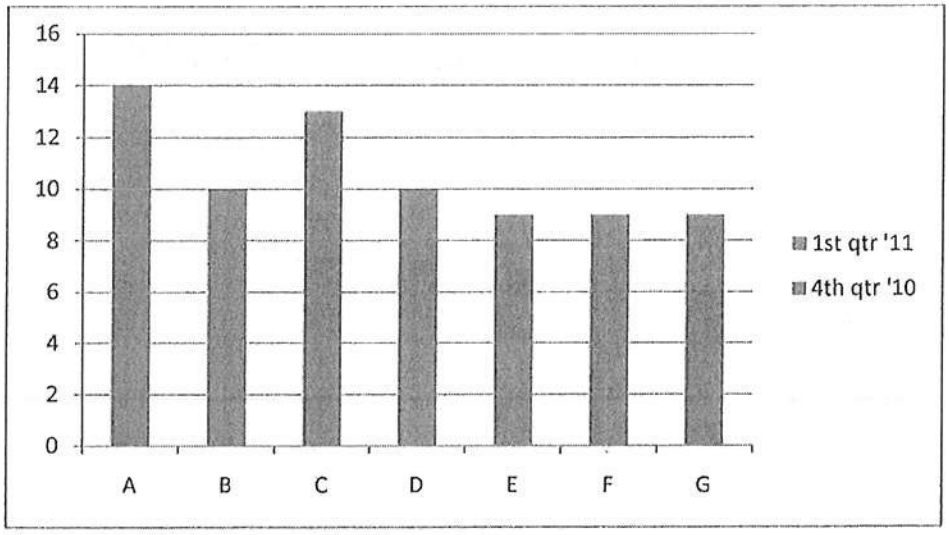
No Category. Incident reported but not currently mandated by contract (i.e. hospitalization not attributable to mental health/behavioral concerns, and medical attention not related to injury.

	4th qtr '10	1st qtr '11	4th qtr '09	1st qtr '10
Category 1	54	34	50	48
Category 2	35	20	24	57
Category 3	172	175	146	162
Category 4	30	27	16	16
Category 5	104	80	128	152
Category 6	11	12	9	10
Categories 2&5	24	15		
No Category	12	20	0	1
Total per qtr	442	383	373	446

QUARTERLY CHARTS DISPLAY OF INCIDENT DATA
April '11 DDD QI Committee Meeting



Number of Critical Incidents per Quarter by Provider
(Previous 6 months & Comparison to Final Quarter of 2009)



Number of Critical Incidents by Quarter
per Individual with Muliple Incidents

QUARTERLY CHART: Incident Data April 1, 2011 to June 30, 2011
DHHS Developmental Disability Division
QI COMMITTEE MEETING, JULY, 2011

Reflects Individuals with Greatest Number of Critical Incidents within 2nd Quarter 2011

Time of Day	Apr – Jun'11	Time of Day	Jan – March '11	Oct – Dec '10	July – Sep '10
8:00 AM – 9:59 AM	7%	6 AM – 8:59 AM	5%	6%	7%
10:00 AM – 2:59 PM	28%	9AM – 4:59 PM	74%	74%	69%
3:00 PM – 4:59 PM	19%				
5:00 PM – 10:59 PM	39%	5 PM – 10:59 PM	19%	18%	18%
11 PM – 7:59 AM	7%	11 PM – 5:59 AM	1%	2%	3%
No time			9%		3%

Table 1: Percent of Incidents Occurring Per Time of Day

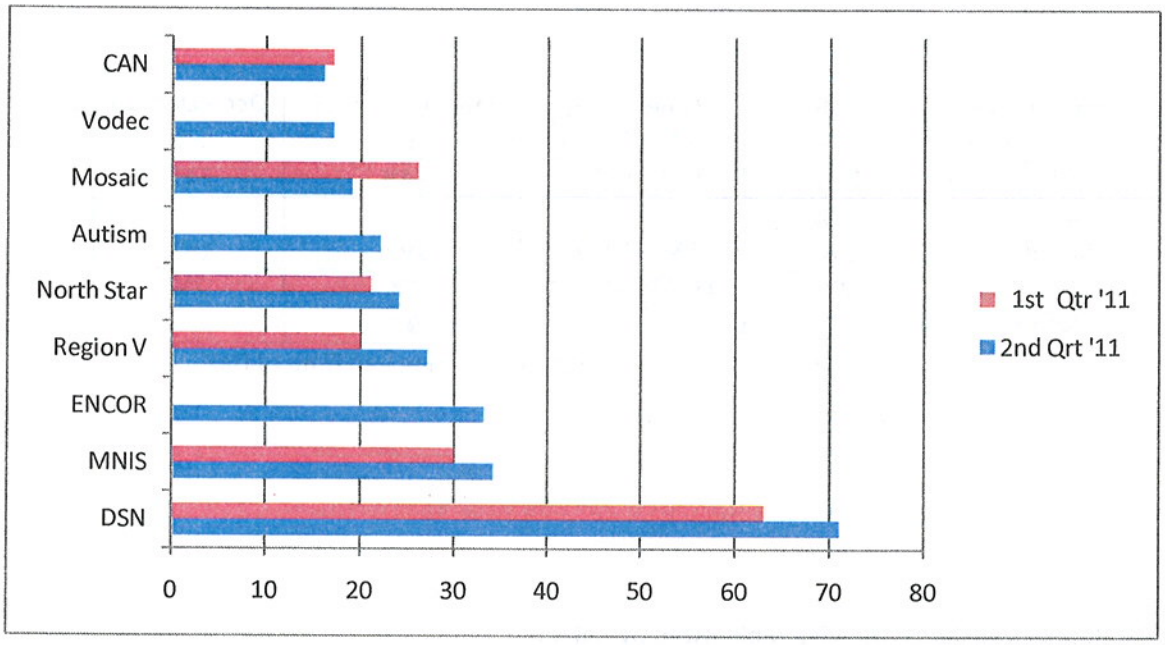
For Reference when reviewing table listed by Category:

1. **Leaving staff supervision where the safety of the individual or others is potentially threatened.**
2. **Hospitalization due to mental health/behavioral concerns.**
3. **Injuries which require medical attention** (Dr. office, ER visit, hospitalization) to individuals, staff persons or others with whom the individual comes in contact.
4. **Injuries involving restraints.**
5. **Police contacts due to behavior.**
6. **Death** (of persons served).

	2nd Qtr '11	1st Qtr '11	4th Qtr '10
Category 1	74	34	54
Category 2	33	20	35
Category 3	194	175	172
Category 4	3	27	30
Category 5	117	80	104
Category 6	11	12	11
Category 2&5	---	15	24
No Category	---	20	12
Total per Qtr	432	383	442

Table 2: Number of Critical Incidents by Category over three calendar quarters

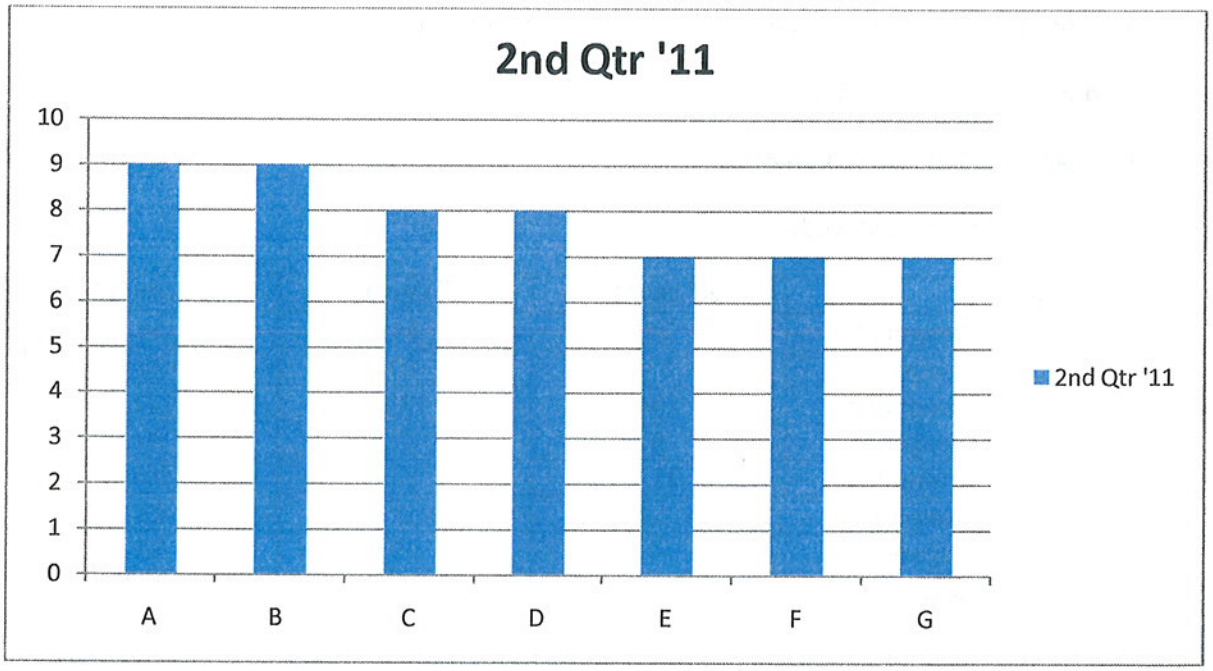
QUARTERLY CHART: Incident Data April 1, 2011 to June 30, 2011
DHHS Developmental Disability Division
QI COMMITTEE MEETING, JULY, 2011



Count of Critical Incidents 2nd Quarter 2011

Reflects Providers with > 15 incidents reported during the quarter

(Note: Providers reflecting one bar on chart had < 15 incidents during previous quarter)



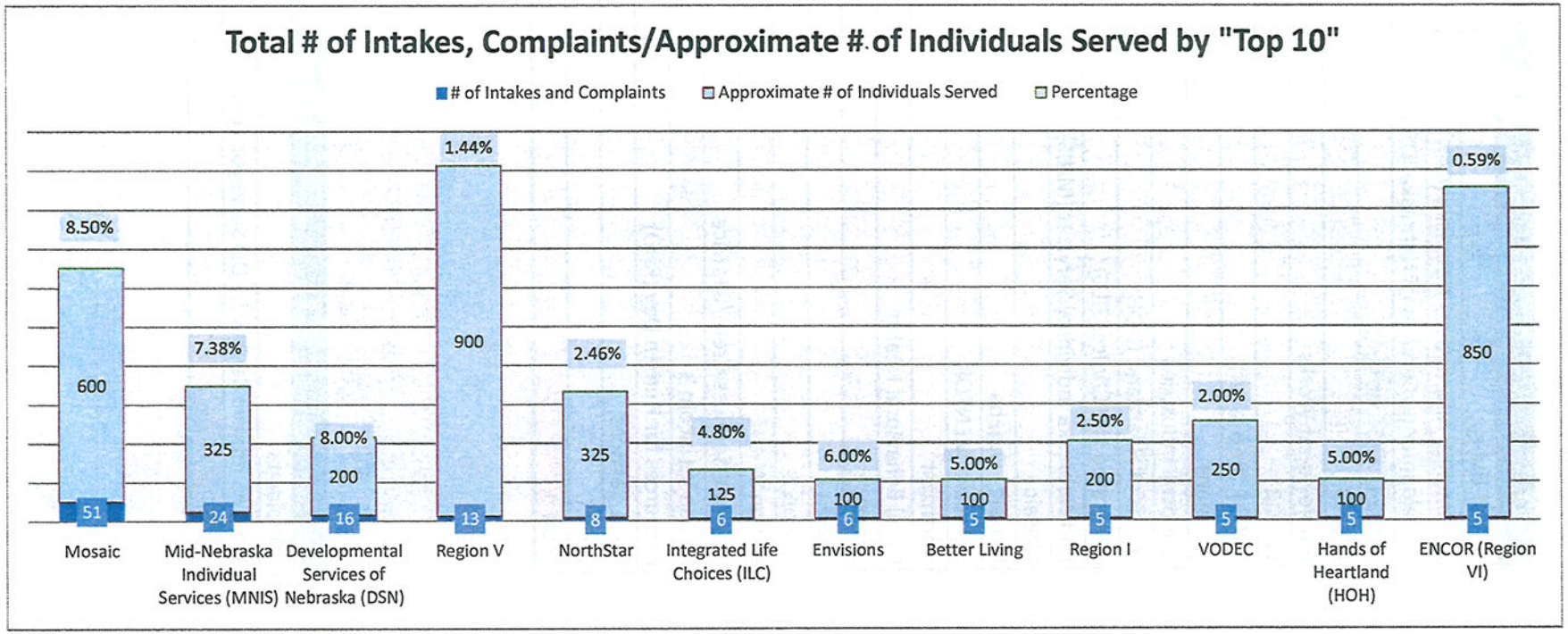
Number of Critical Incidents by Quarter (reflects individuals with multiple incidents of 7 or more)

April 1, 2011 - June 30, 2011 (2nd Quarter - 2011)
Community-Based DD Provider Intakes and Complaints

"Top 10"

Provider	Total
Mosaic	51
Other	42
Mid-Nebraska Individual Services (MNIS)	24
Developmental Services of Nebraska (DSN)	16
Region V	13
NorthStar	8
Integrated Life Choices (ILC)	6
Envisions	6
Better Living	5
Region I	5
VODEC	5
Hands of Heartland (HOH)	5
ENCOR (Region VI)	5
Total	**191**

"Other" Type	Total
Beatrice State Developmental Center	8
Does not receive DD-funded services	8
School	4
Home (non-DD provider related)	3
Mosaic ICF/MR	4
Parent's home	7
Community Supports Program (CSP)	3
Individual's Payee	1
Service Coordination Only	1
Non-DD Facility	2
A&D Waiver	1
Total	42



April 1, 2011 - June 30, 2011 (2nd Quarter - 2011)
Community-Based DD Provider Intakes and Complaints

Provider	Total
Better Living	5
Community Alternatives Nebraska (CAN)	2
Developmental Services of Nebraska (DSN)	16
DHHS-DDD SC only	1
ECCHO	3
Employment Works	1
ENCOR	1
ENCOR (Region VI)	5
Envisions	6
Goodwill Industries	2
Hands of Heartland (HOH)	5
Integrated Life Choices (ILC)	6
Mid-Nebraska Individual Services (MNIS)	24
Mosaic	51
Mosaic - Omaha	1
Nebraska MENTOR	2
NorthStar	8
Omni Behavioral Health	1
Other	42
Region I	5
Region II	2
Region V	13
Region V Services-Crete/Beatrice	1
Region V-Lincoln 3	1
Resources for Human Dev (RHD)	3
VITAL Services	2
VODEC	5
Total	**214**

Source	Total
Complaints	5
APS/CPS Intakes Review by DD Surveyor Team	209
Total	**214**

Numbers by Provider

IPP Review Charts

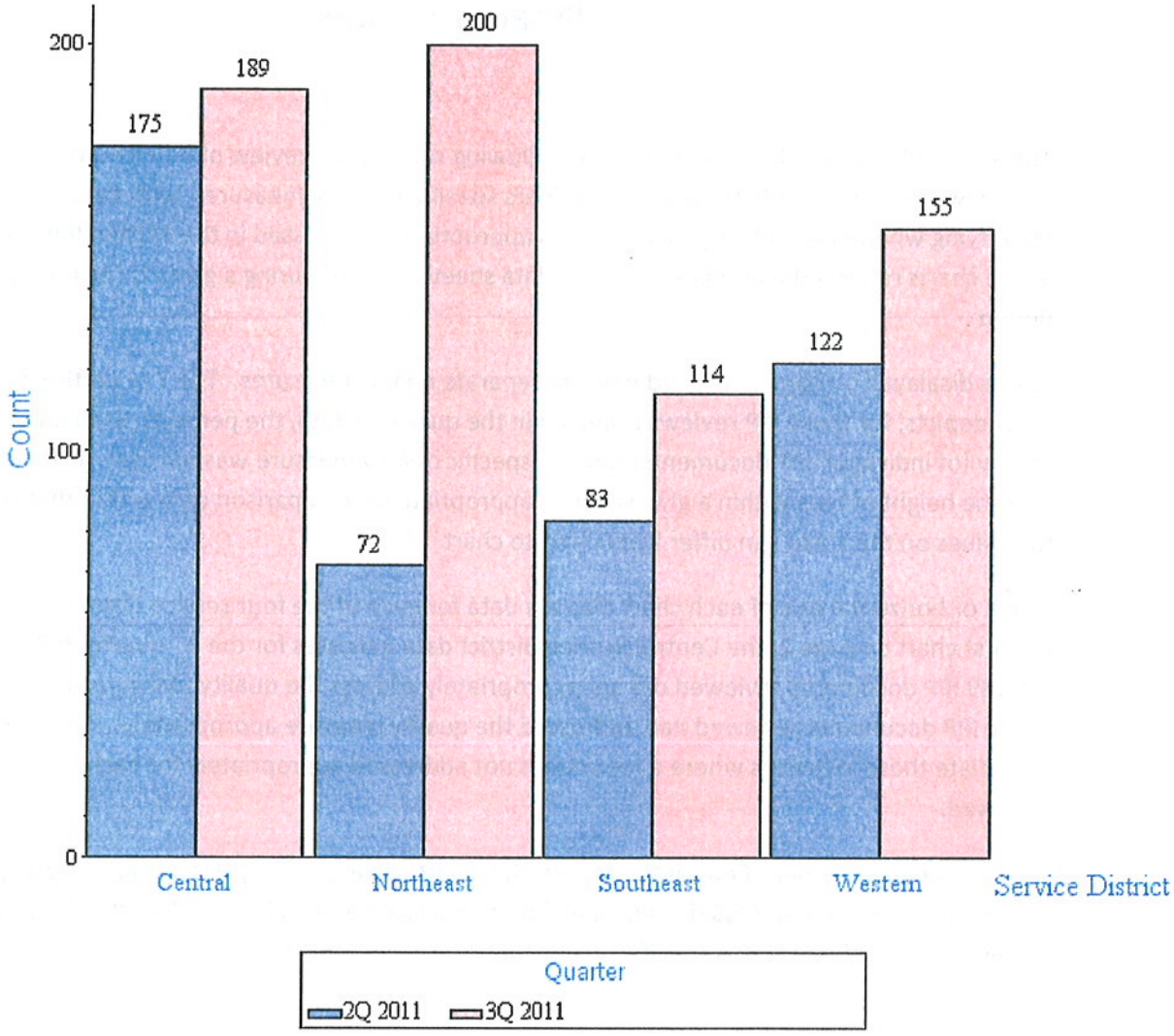
The attached charts reflect aggregate data following supervisory review of IPP documents. The process of review of individual IPP documents considers specified quality measures, with data collection identifying whether the quality measure was appropriately addressed in the written IPP. The first page of the charts reflects the number of review data sheets entered during a given three month (quarter) period .

Charts displayed on page 2 forward indicate separate quality measures. The Y or vertical axis of each chart depicts, for those IPP reviews reflected in the quarterly data, the percent(%) that the supervisory review (of individual IPP documents) found a specific quality measure was not met. It should be noted that the height of bars within a given chart is appropriate for comparison only within that chart, since the values on the Y axis can differ from chart to chart.

The X or horizontal axis of each chart displays data for each of the four service districts. For example, in the first chart on page 2, the Central Service District data indicates for the 3rd quarter of 2011, 1.6% of the 189 IPP documents reviewed did not appropriately address the quality measure. In essence, >98% of the IPP documents reviewed had addressed the quality measure appropriately. The supervisor can remediate those instances where a measure is not addressed appropriately for each IPP that is reviewed.

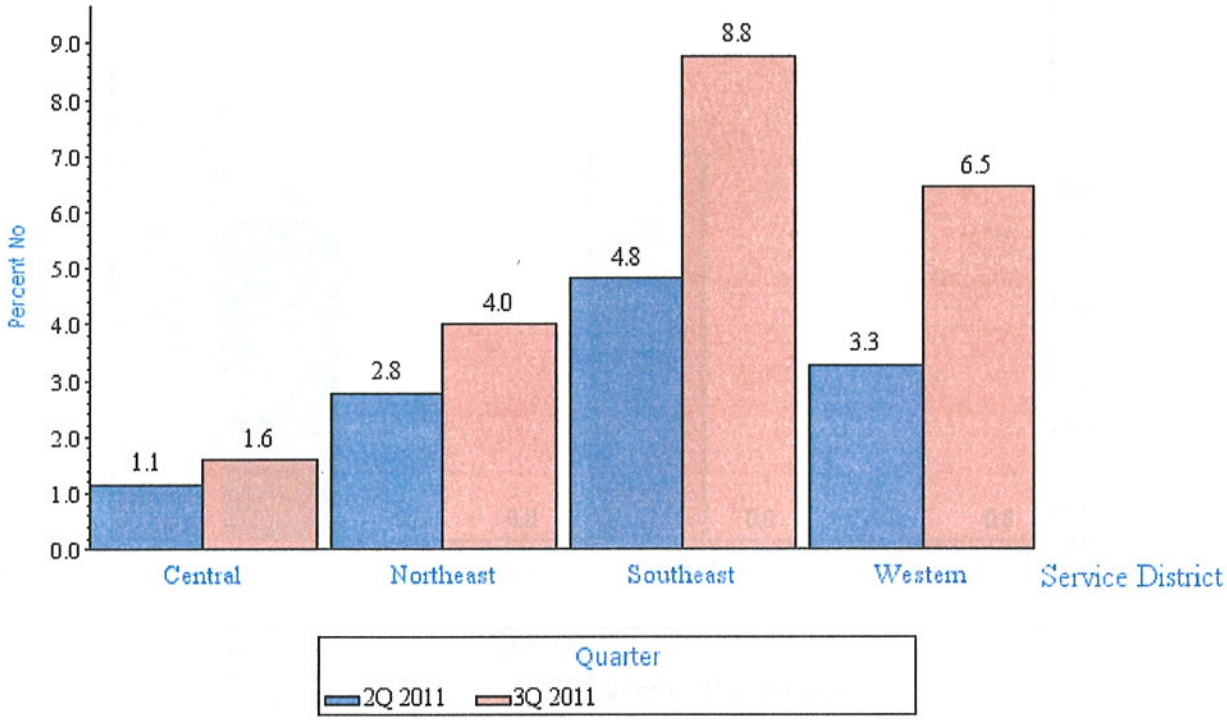
The Quality Improvement Committee reviews the charts on a quarterly basis, and follows up on those instances when less than 95% (i.e. individual bars on a chart exceed 5% "NO" on the Y axis) of the aggregate data reflects that a specific quality measure is not met.

IPP Reviews by Service District by Quarter



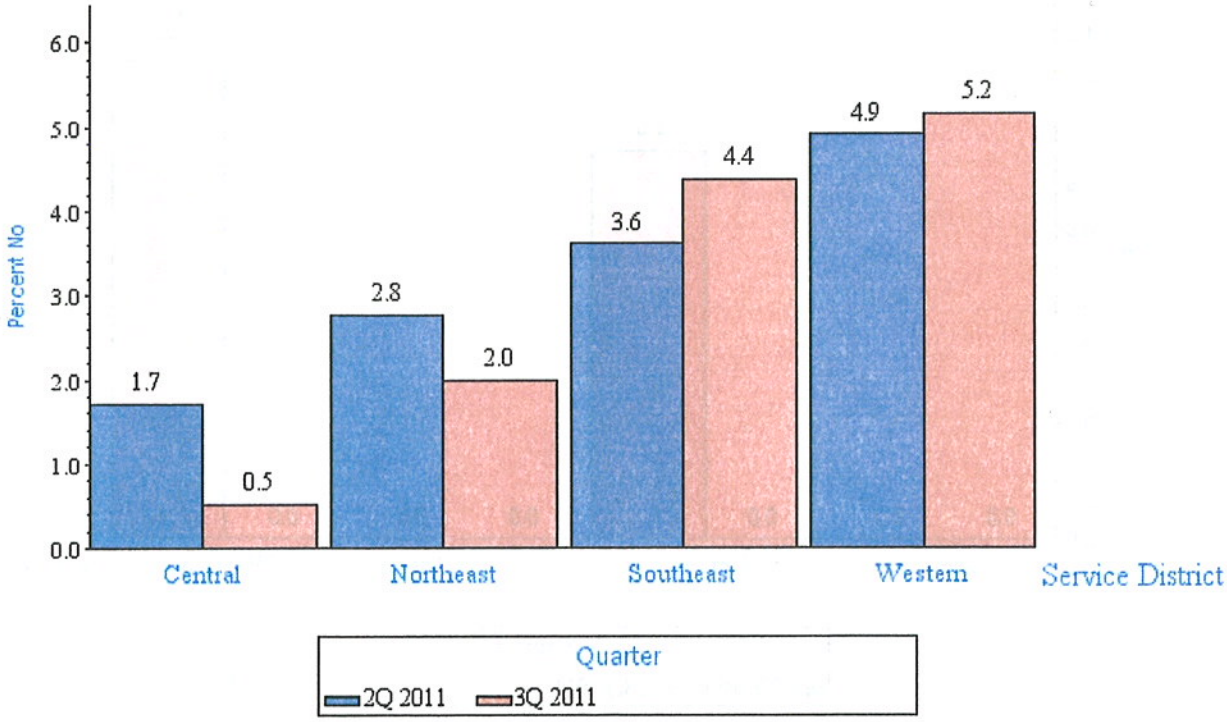
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

At a minimum the IPP/IFSP is developed annually and reviewed semi annually.



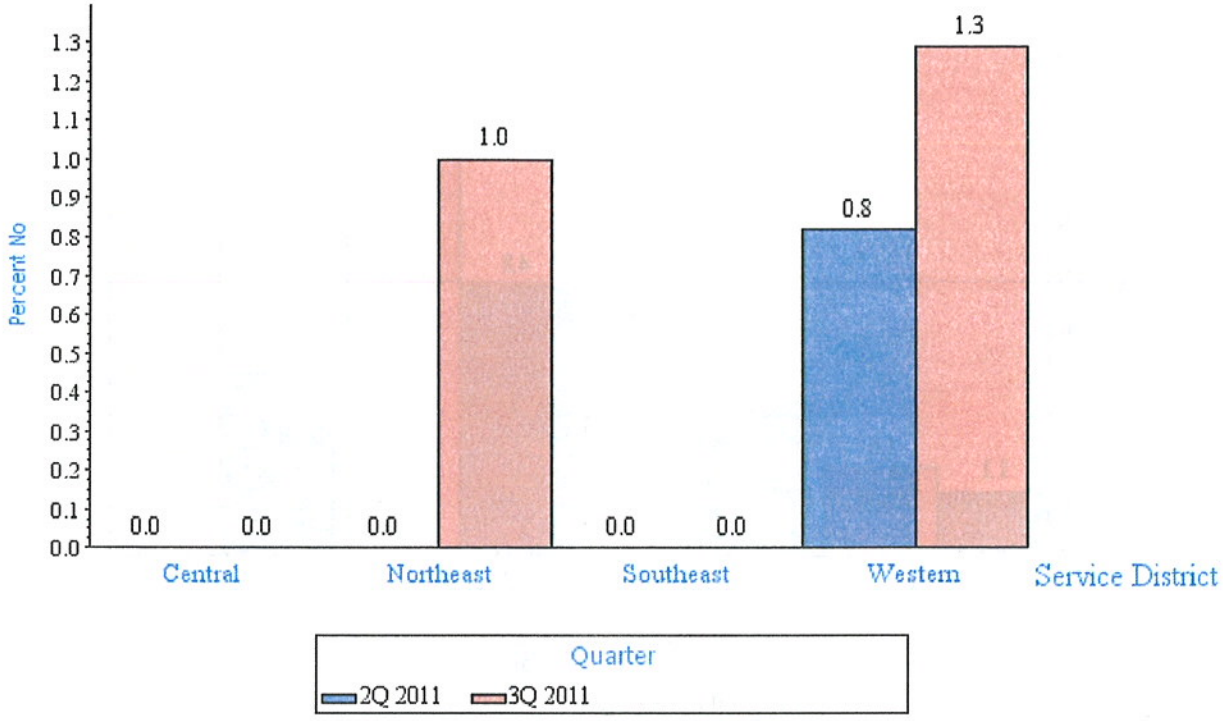
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Individual or legal guardian participated in make a choice of waiver providers.



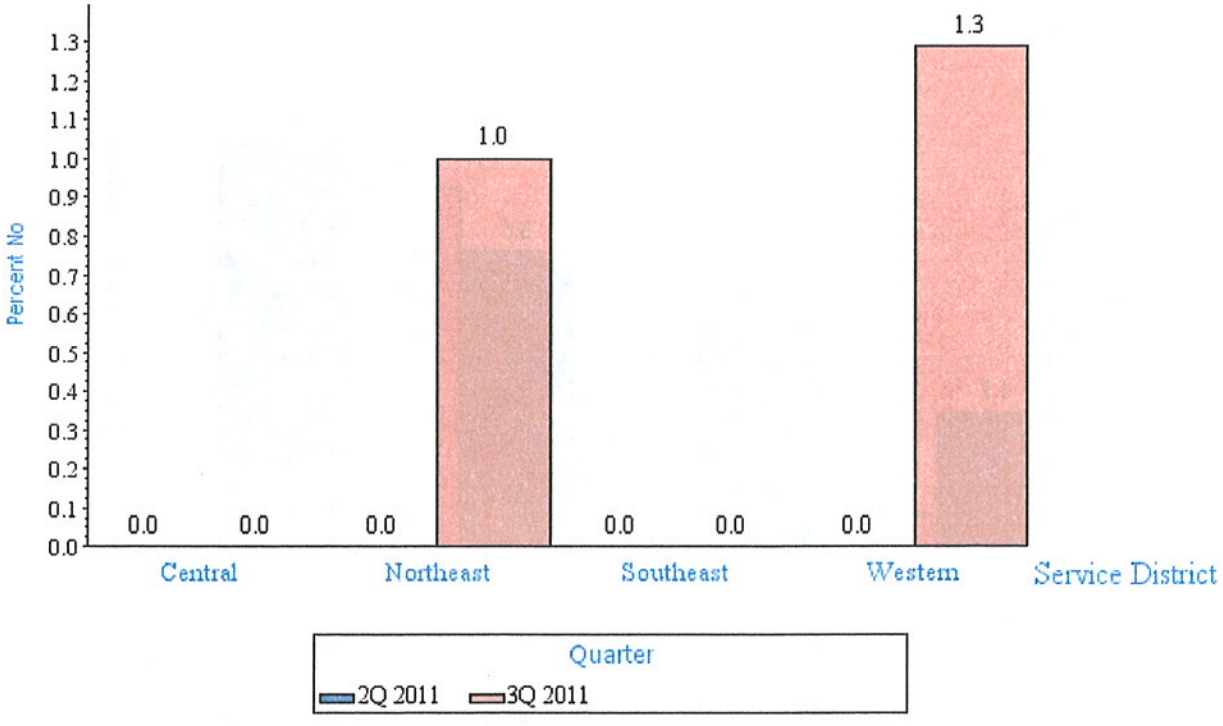
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Required assessments document - strengths.



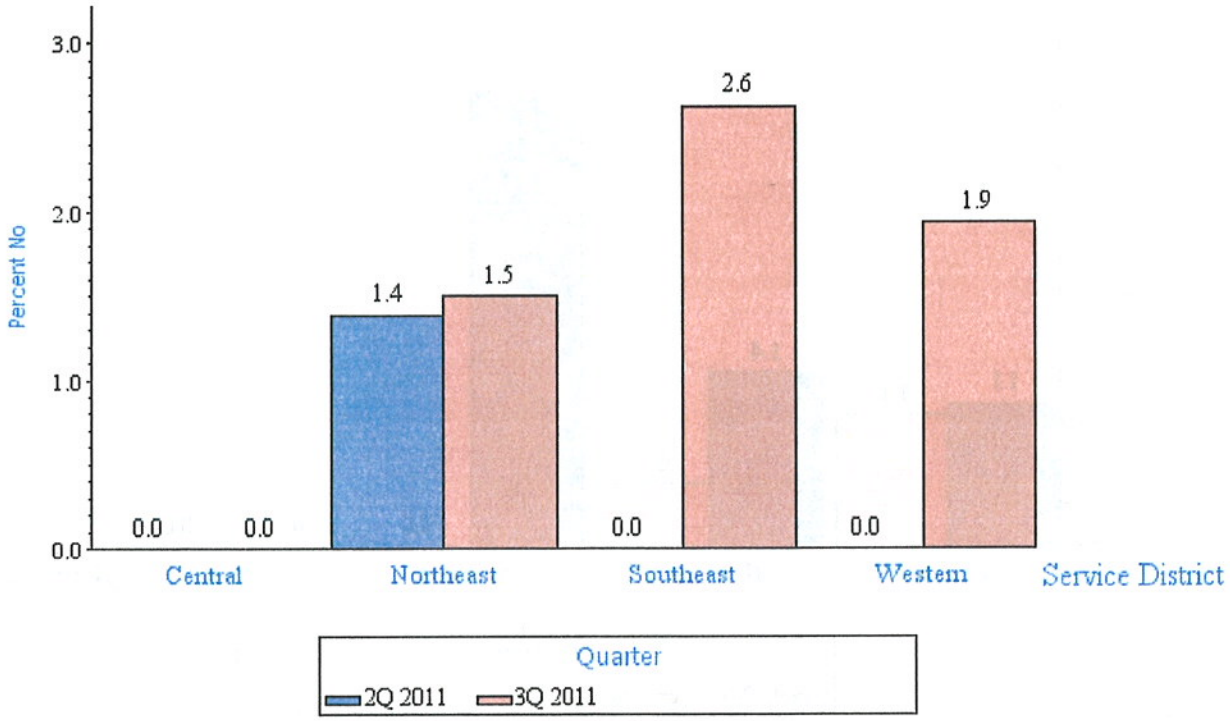
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Required assessments document - needs.



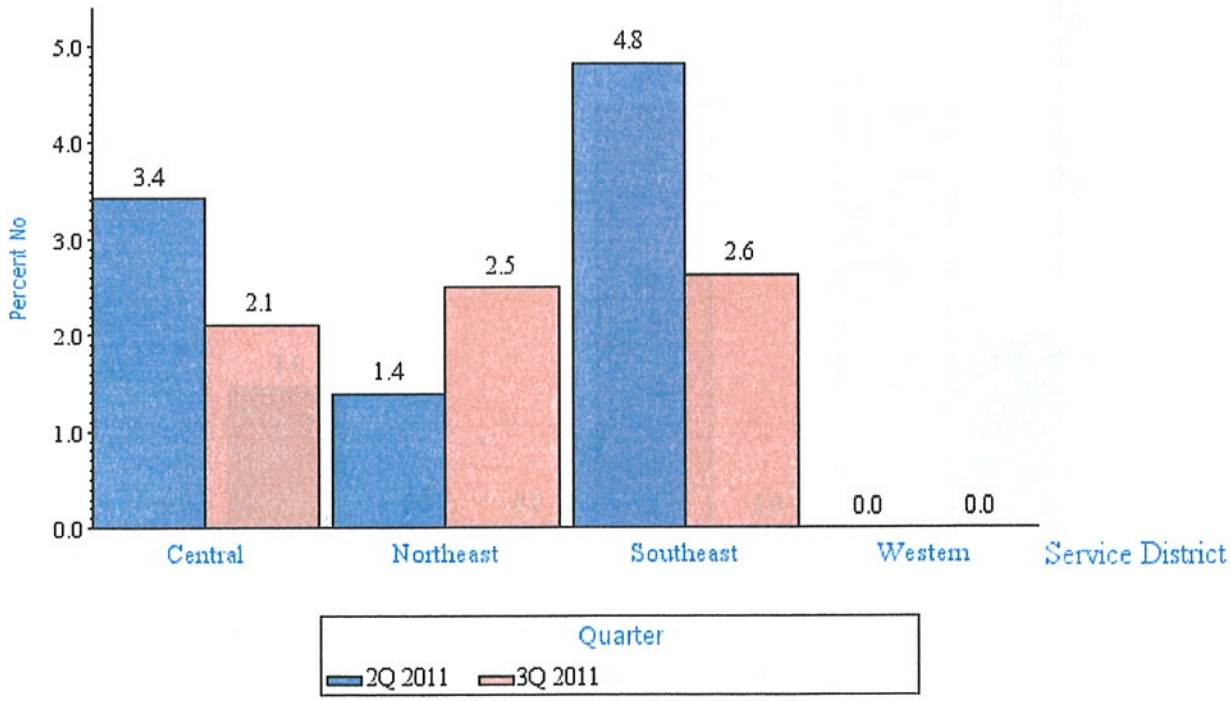
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Required assessments document - preferences.



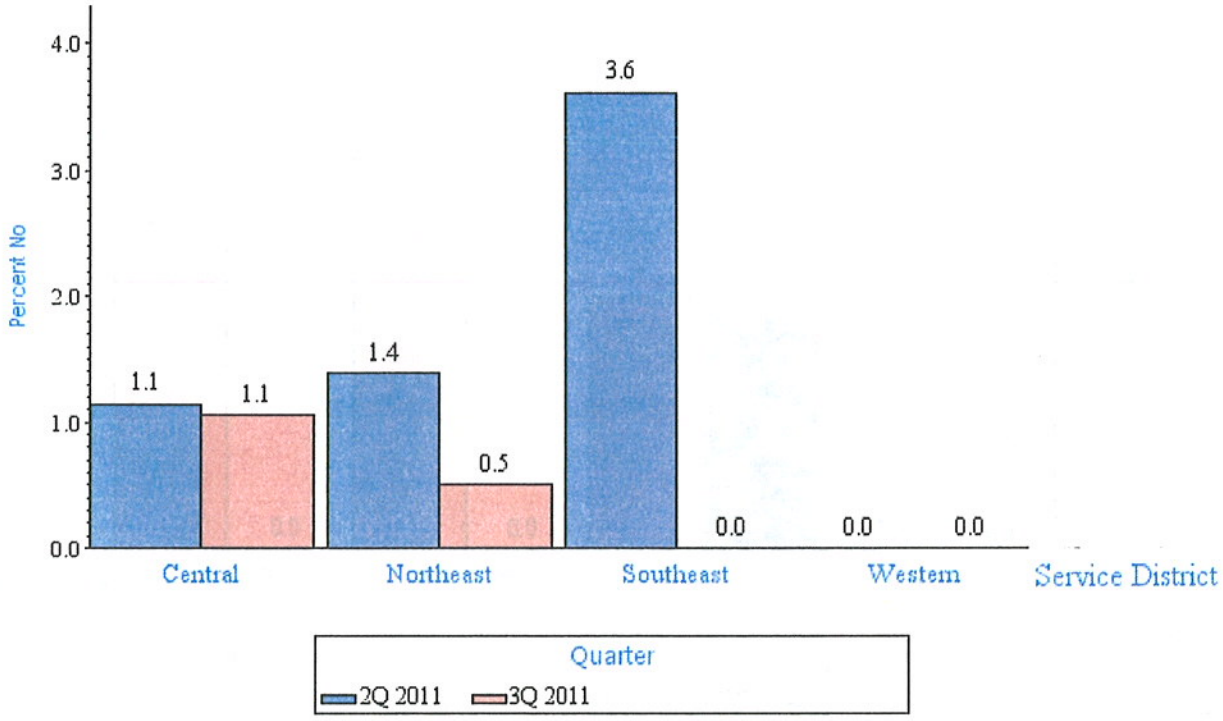
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

If any medication to manage behavior is in place, the name of the medication, dosage, reason for the medication and specific behavior to be affected by the medication is documented.



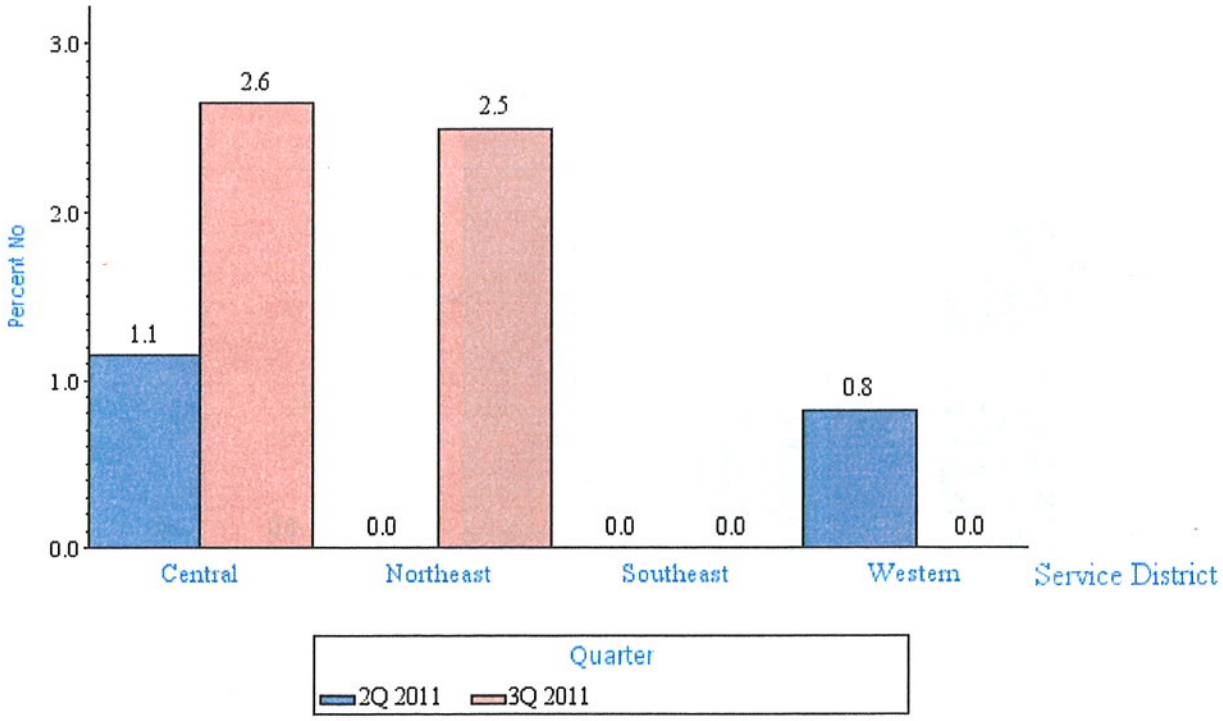
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

The IPP/IFSP has documentation of whether the drug is reviewed on an ongoing basis by a physician.



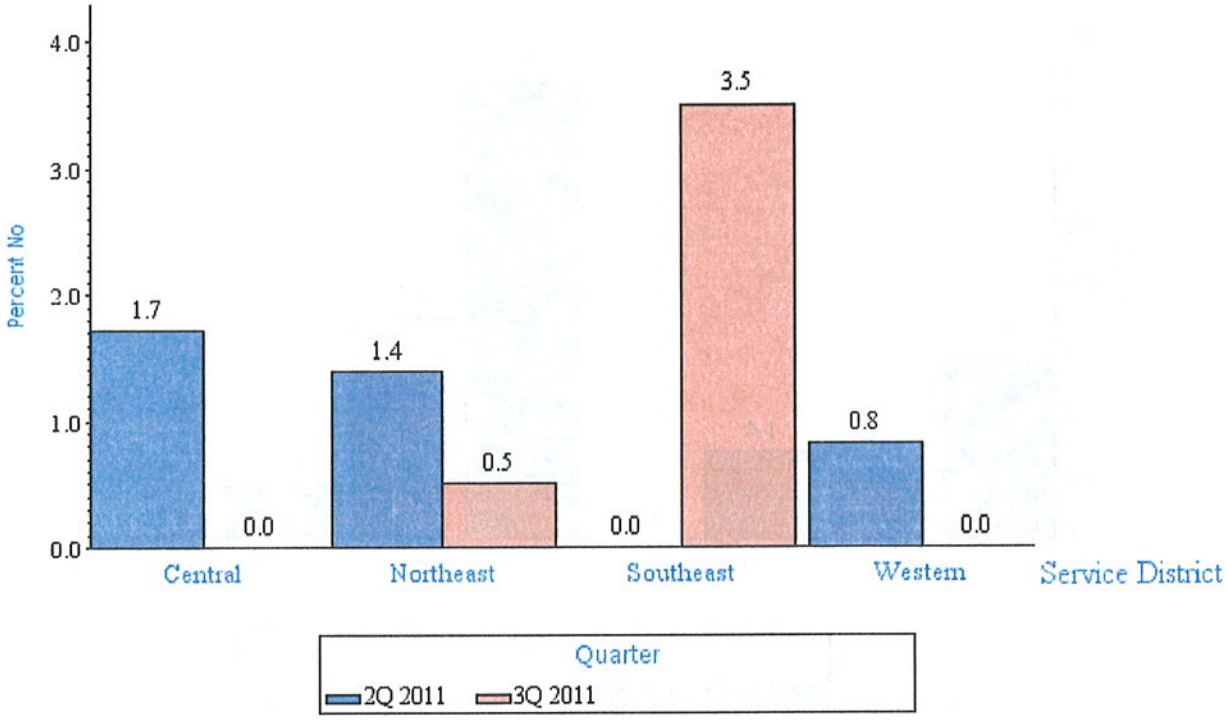
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

If medication to manage behavior is prescribed, there is a documented behavior supports plan and safety plan.



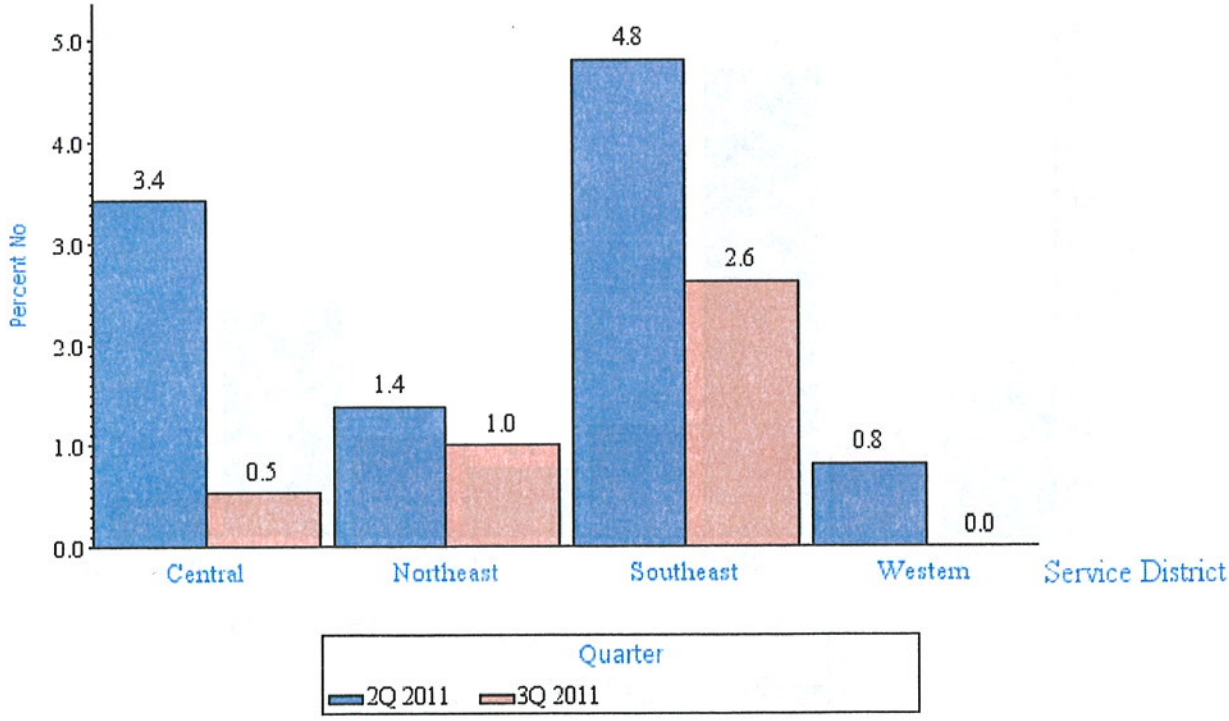
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Restrictions have a documented rationale.



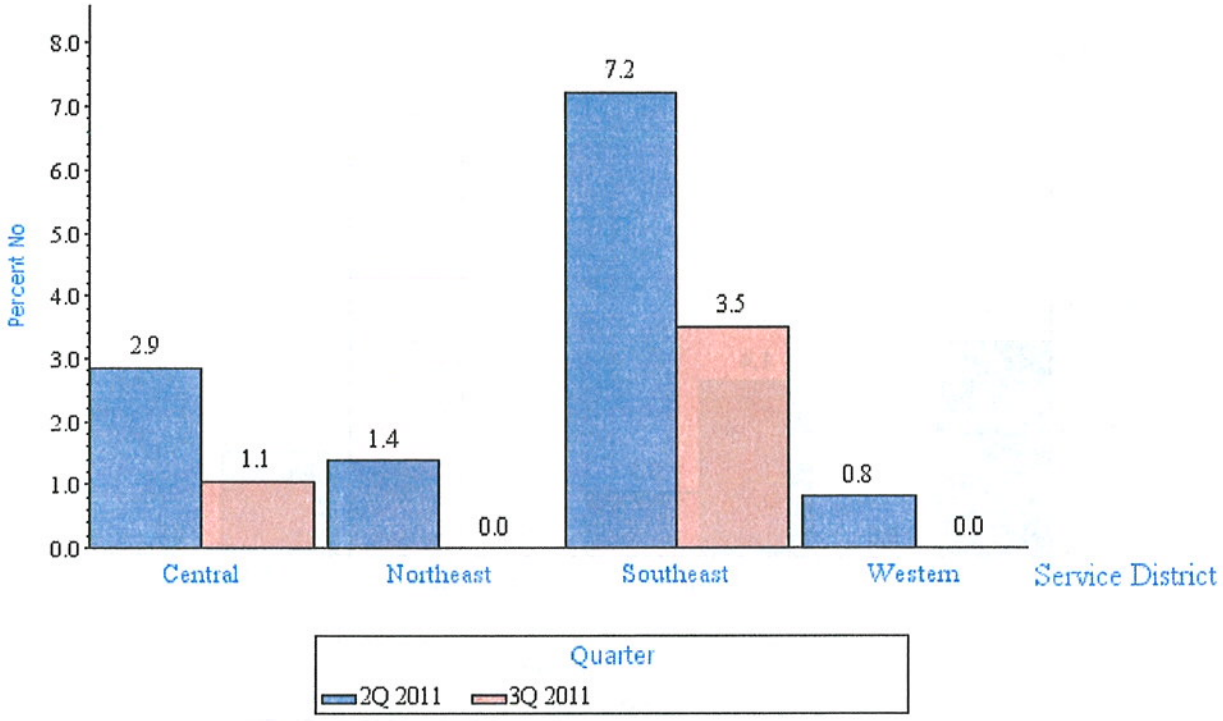
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Restrictions have documentation that due process procedures were followed.



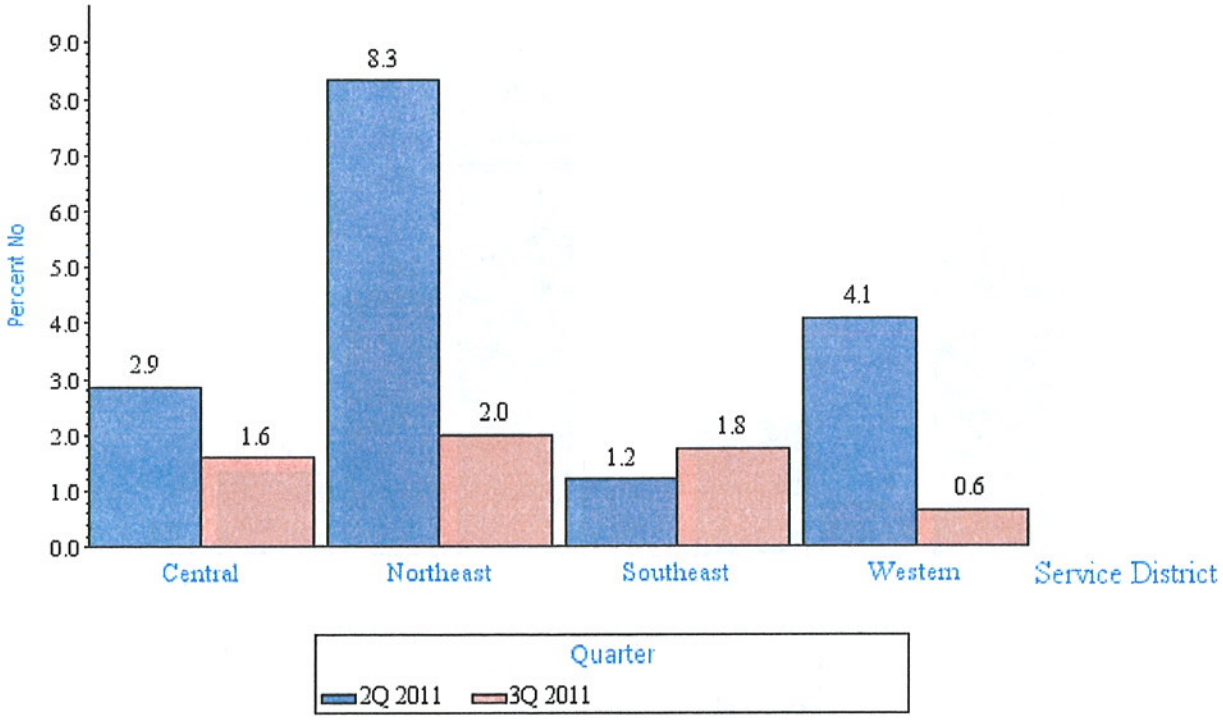
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

A plan to reinstate the right is documented, including methods and time frames.



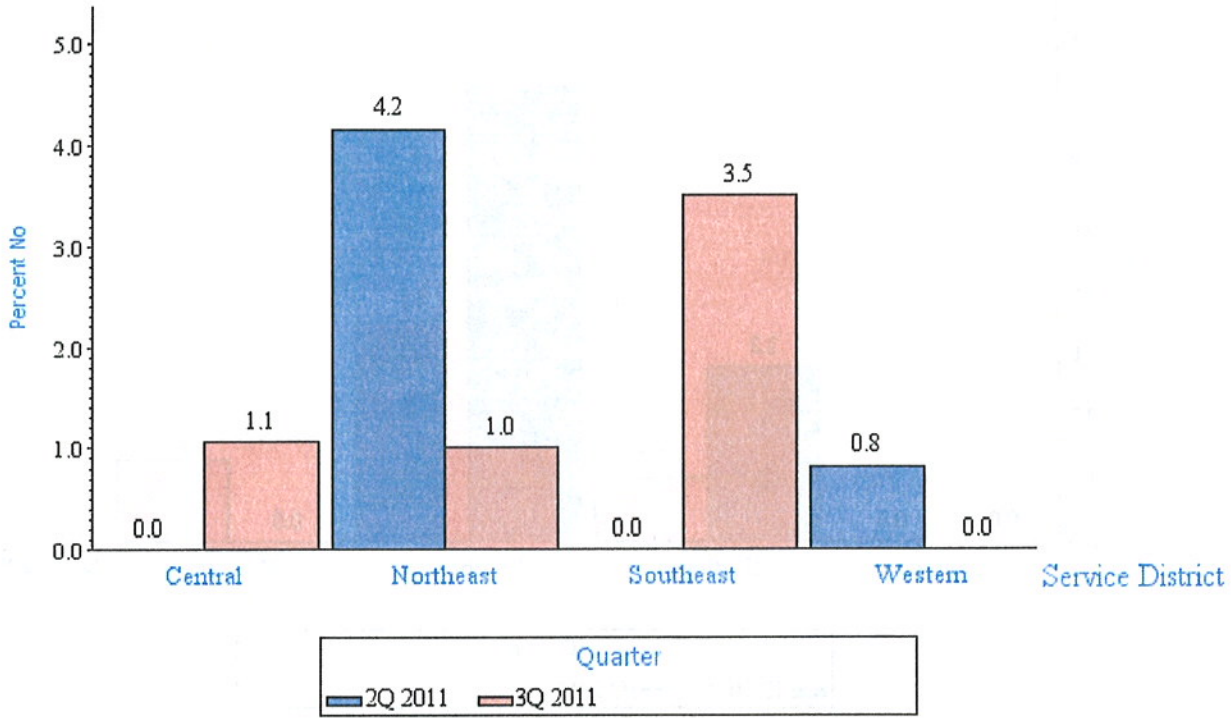
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Restrictions of rights have written consent from the individual or their legal guardian, as appropriate.



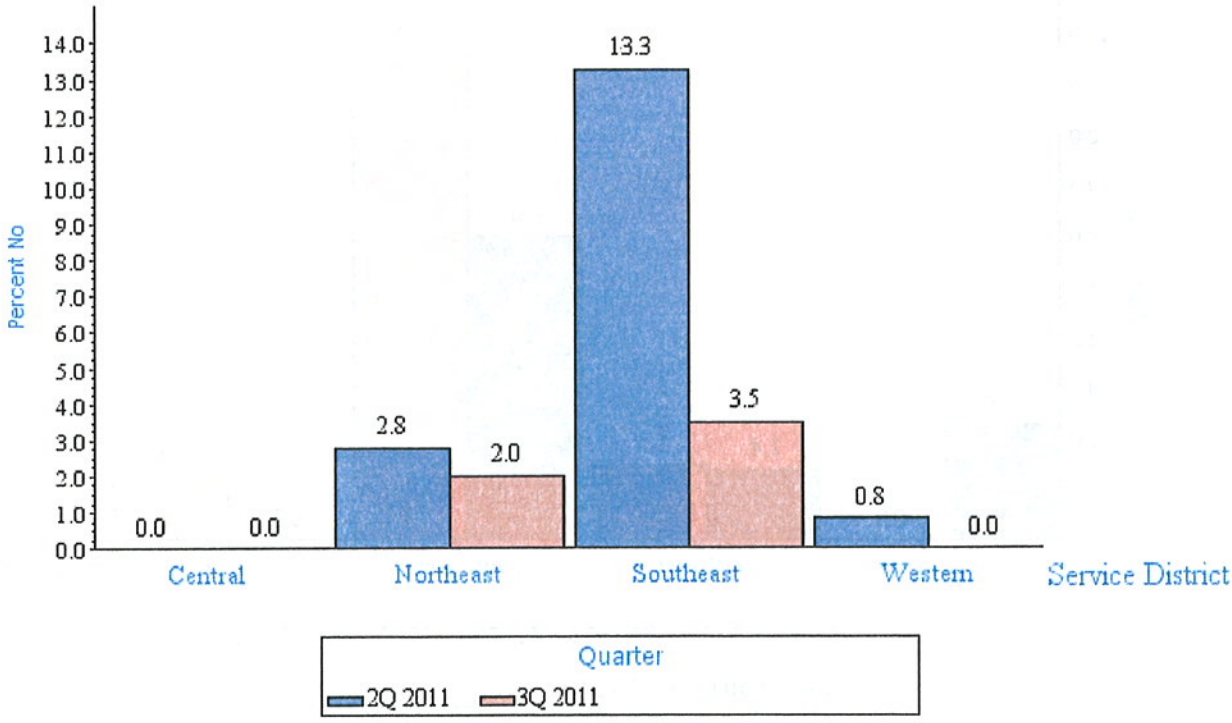
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Required medical assessment has been submitted.



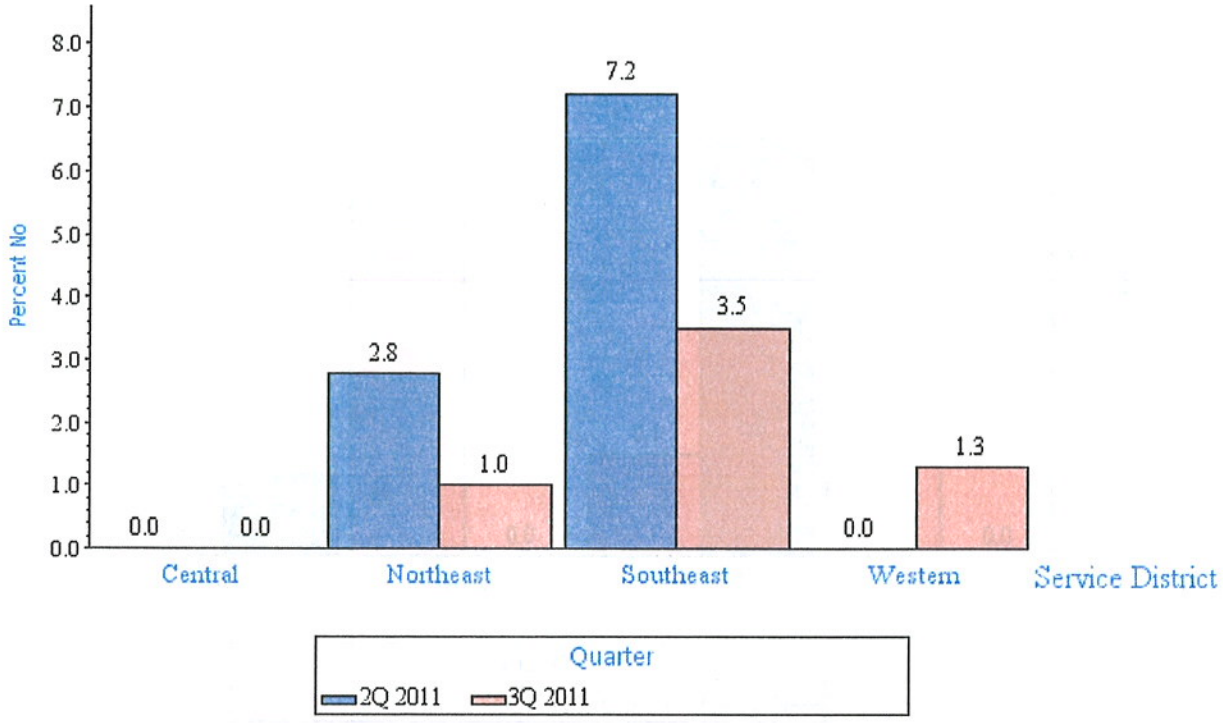
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Discussion of assessments is documented.



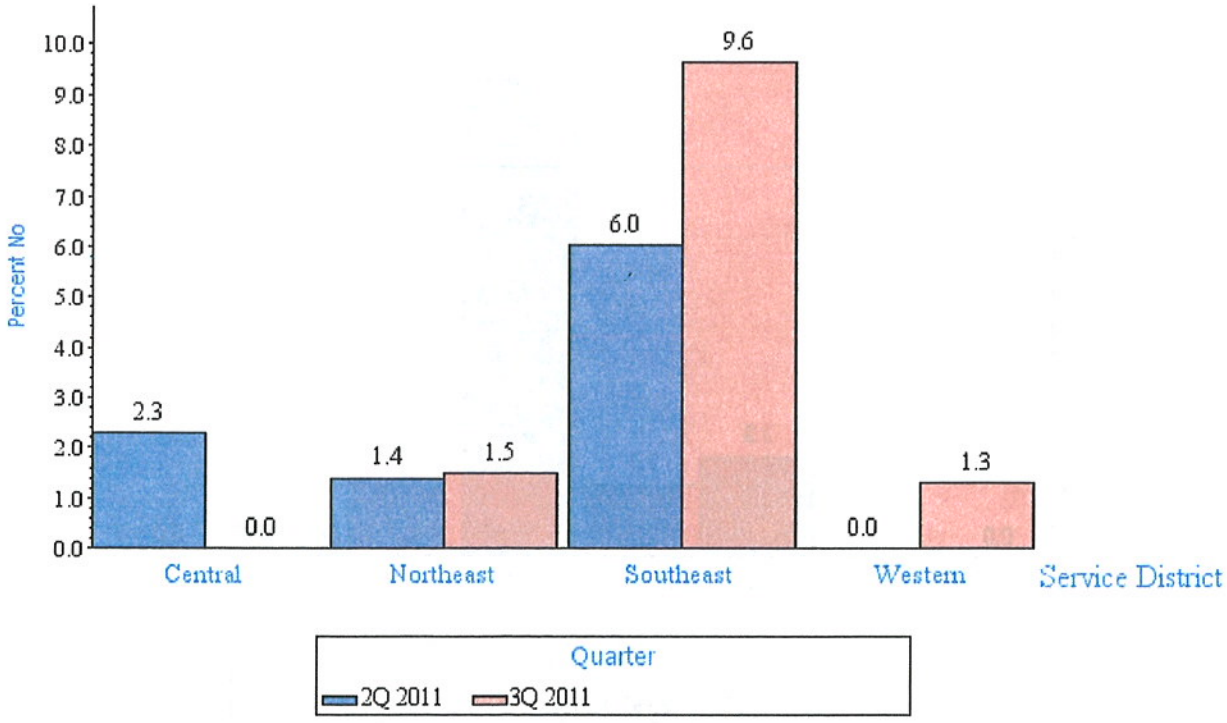
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Did assessments evaluate requested domains?



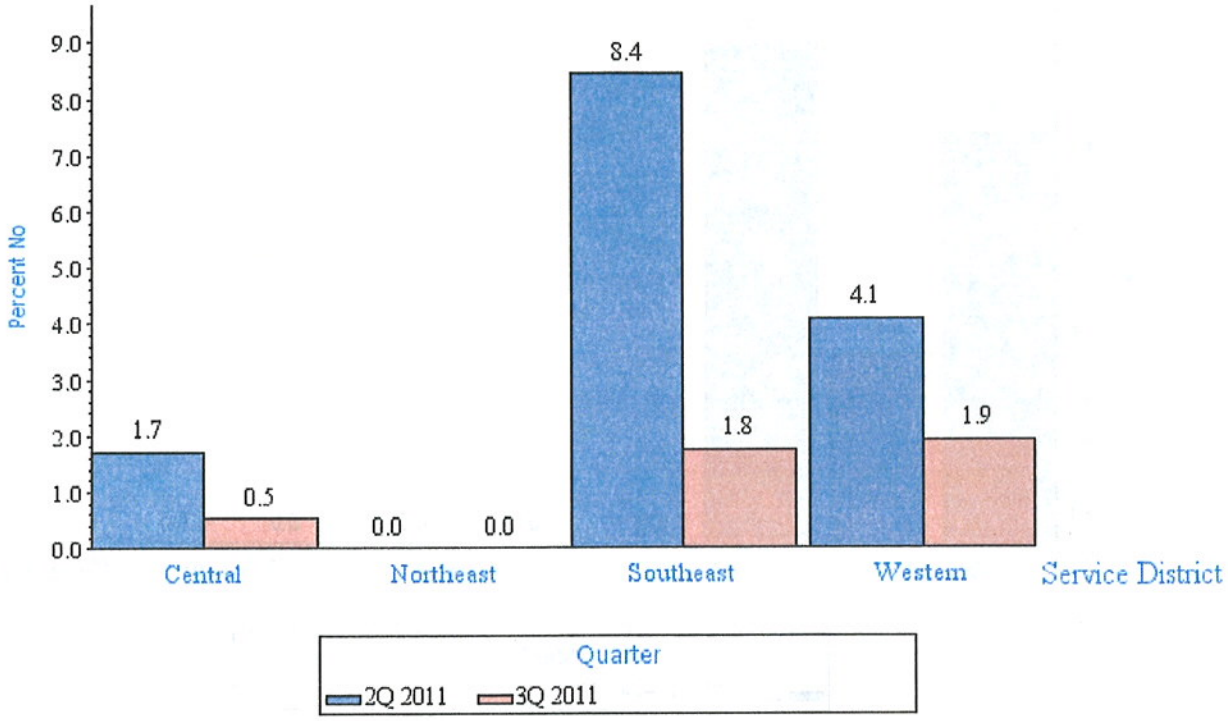
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Plan for the future is addressed by strategies and outcomes.



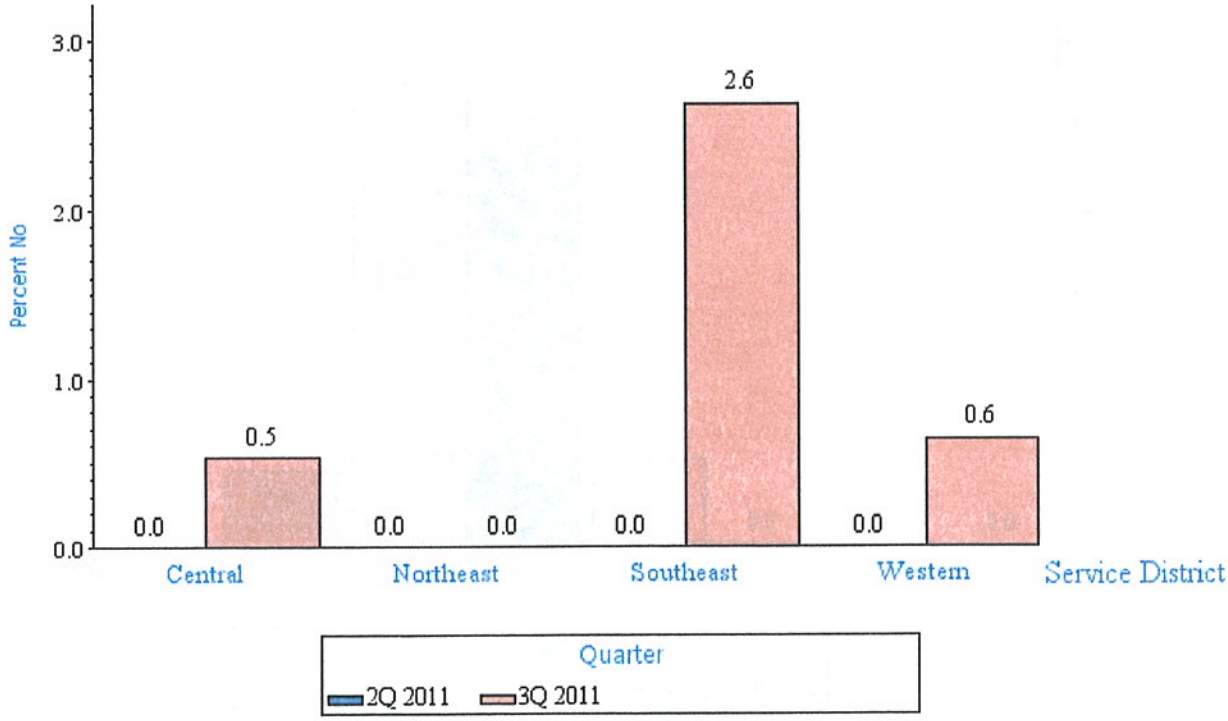
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Assessed needs are addressed.



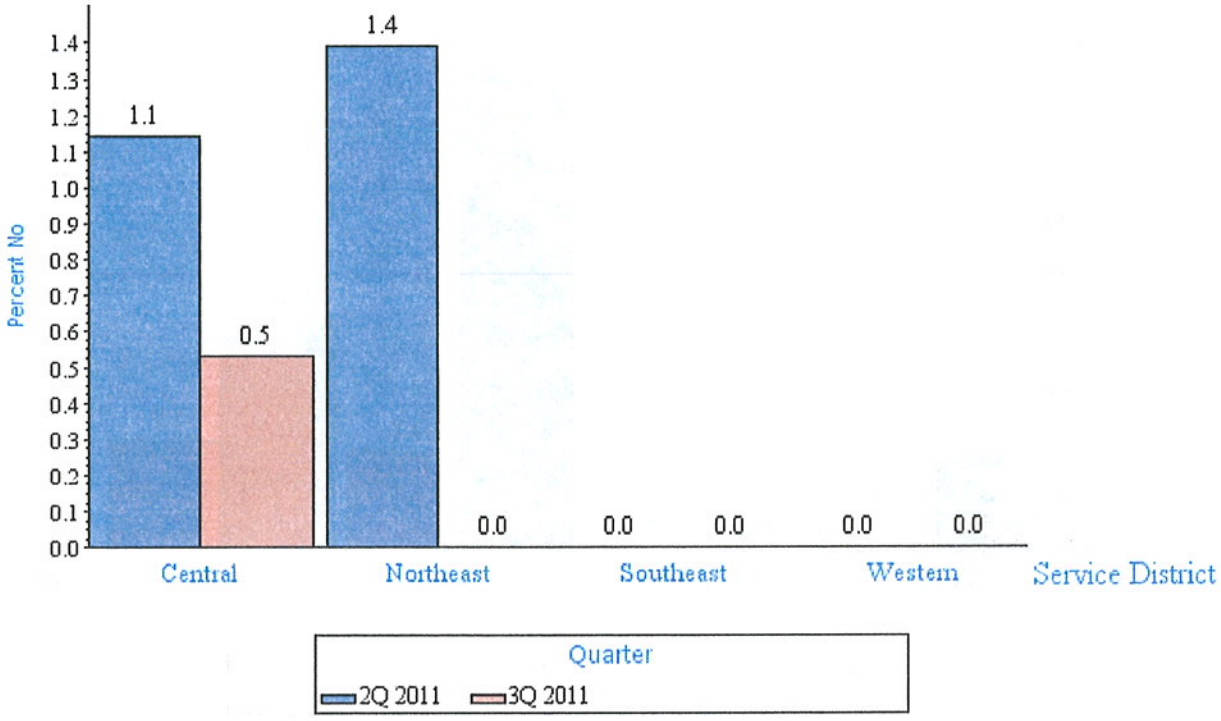
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

There is appropriate habilitation for each applicable service.



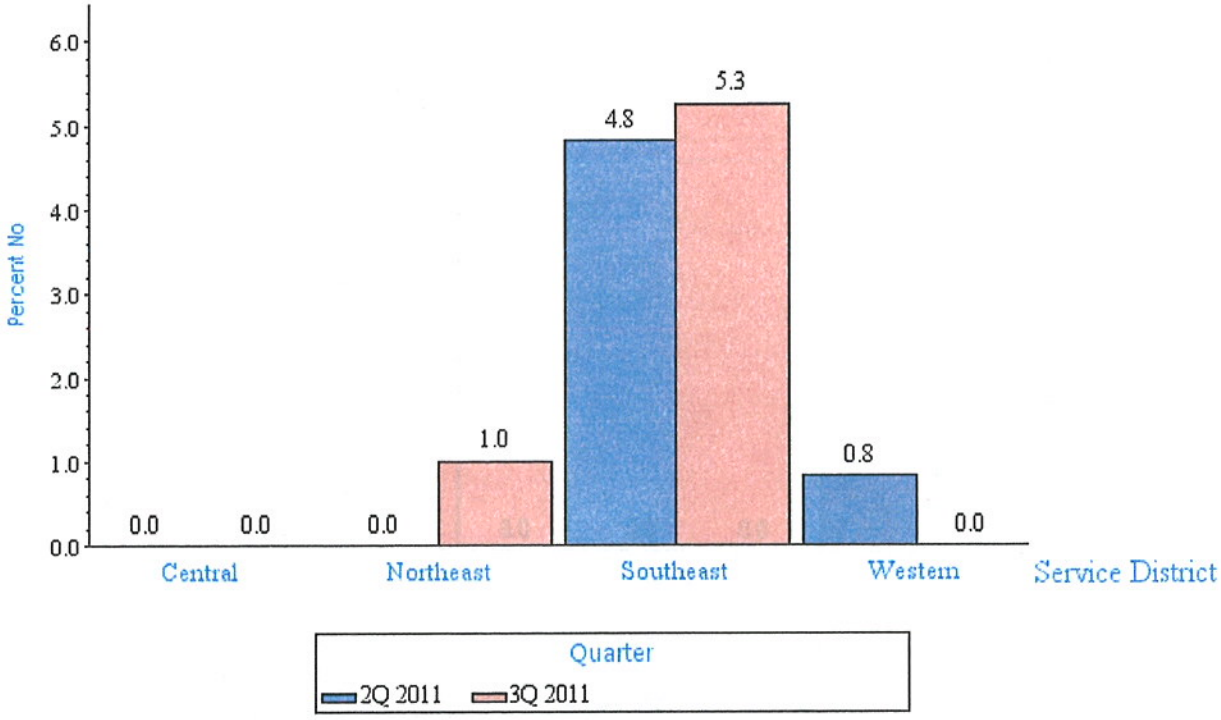
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

The IPP/IFSP was revised due to a change(s) in a person's needs.



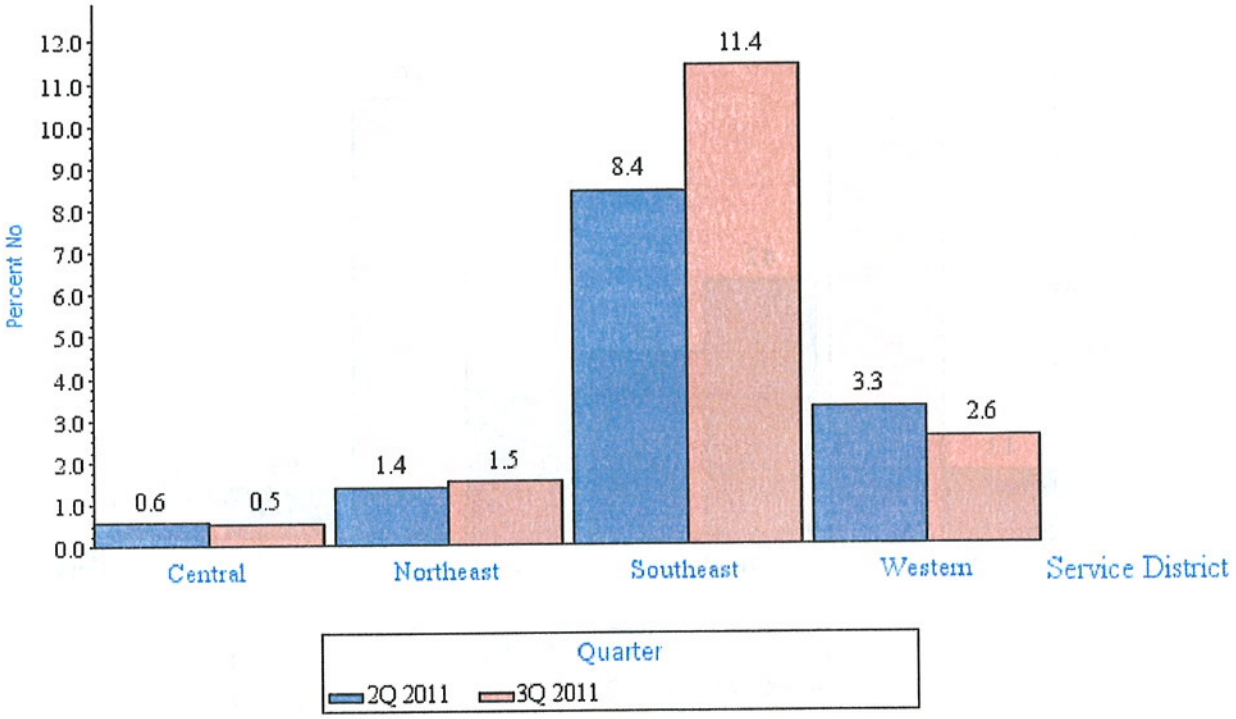
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Medical services are specified and documented on the IPP/IFSP.



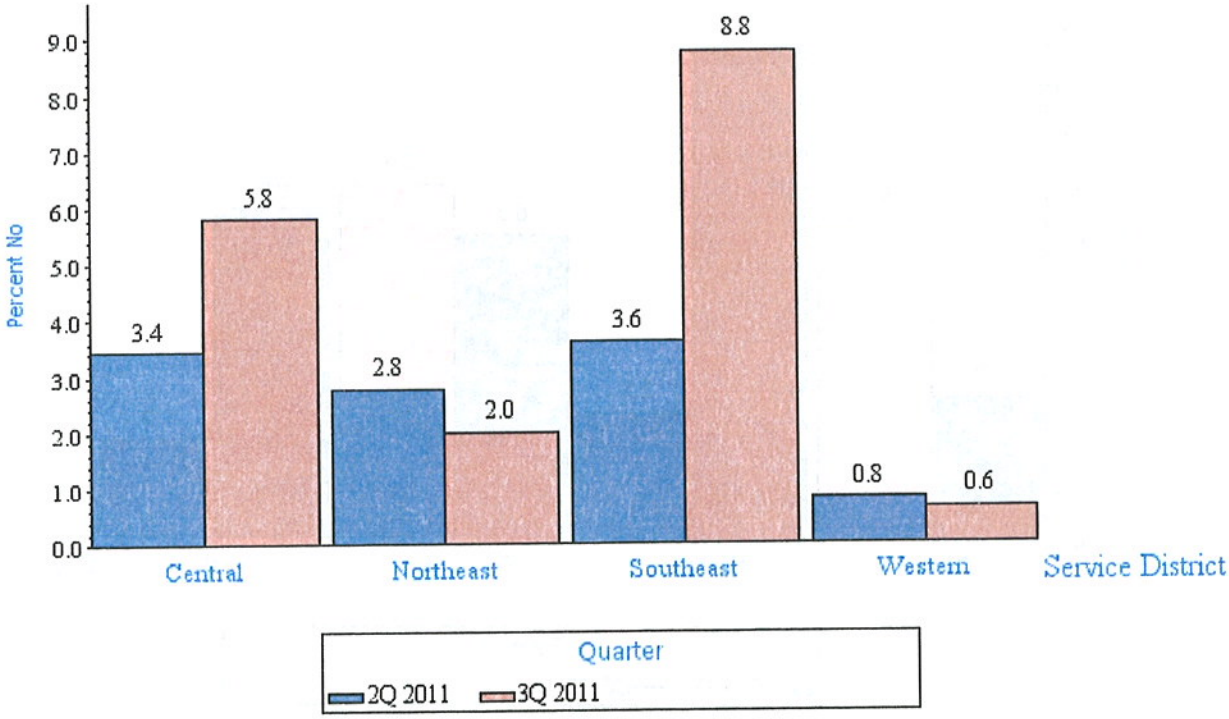
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

The frequency and person responsible for each identified service need is documented.



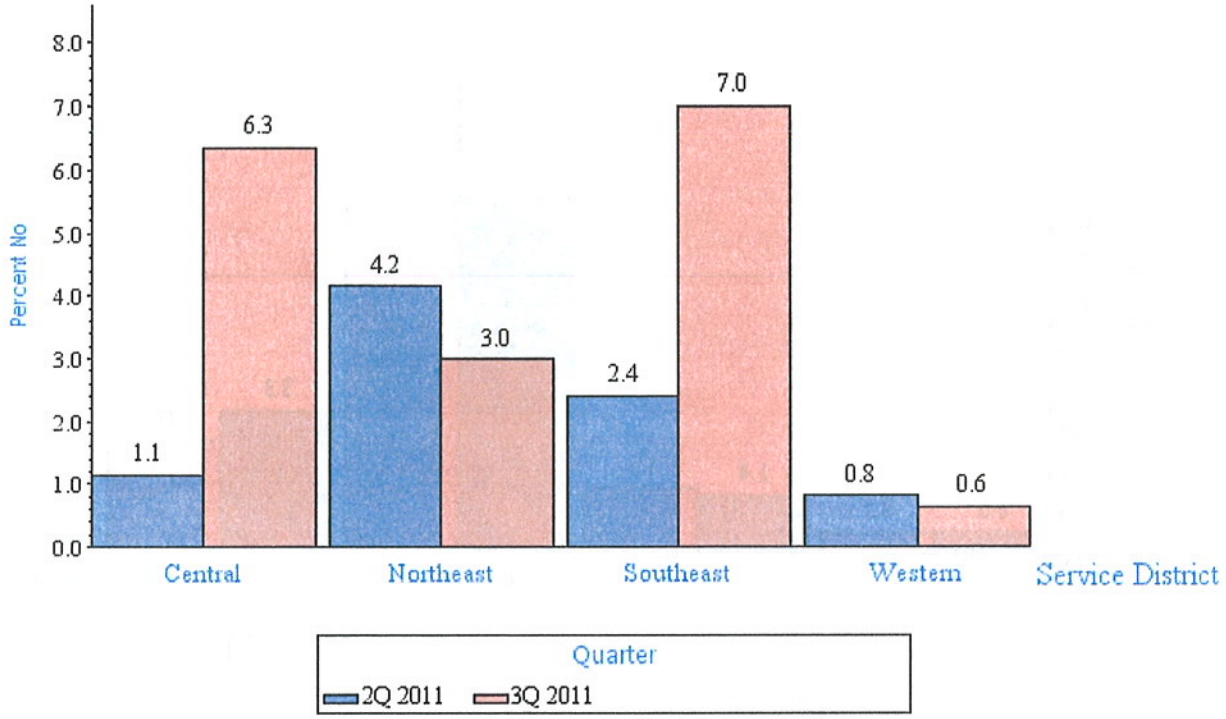
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

The documented authorized units match the state's electronic authorization and billing system.



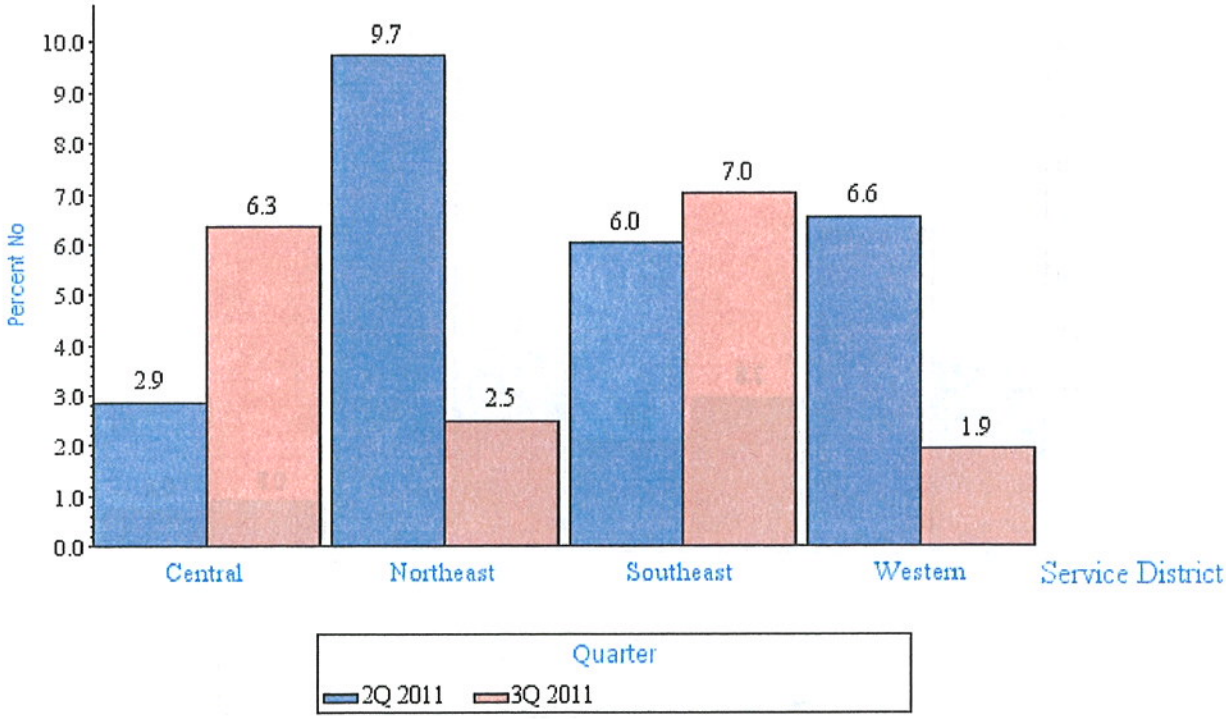
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Documented authorized service codes match the state's electronic authorization and billing system.



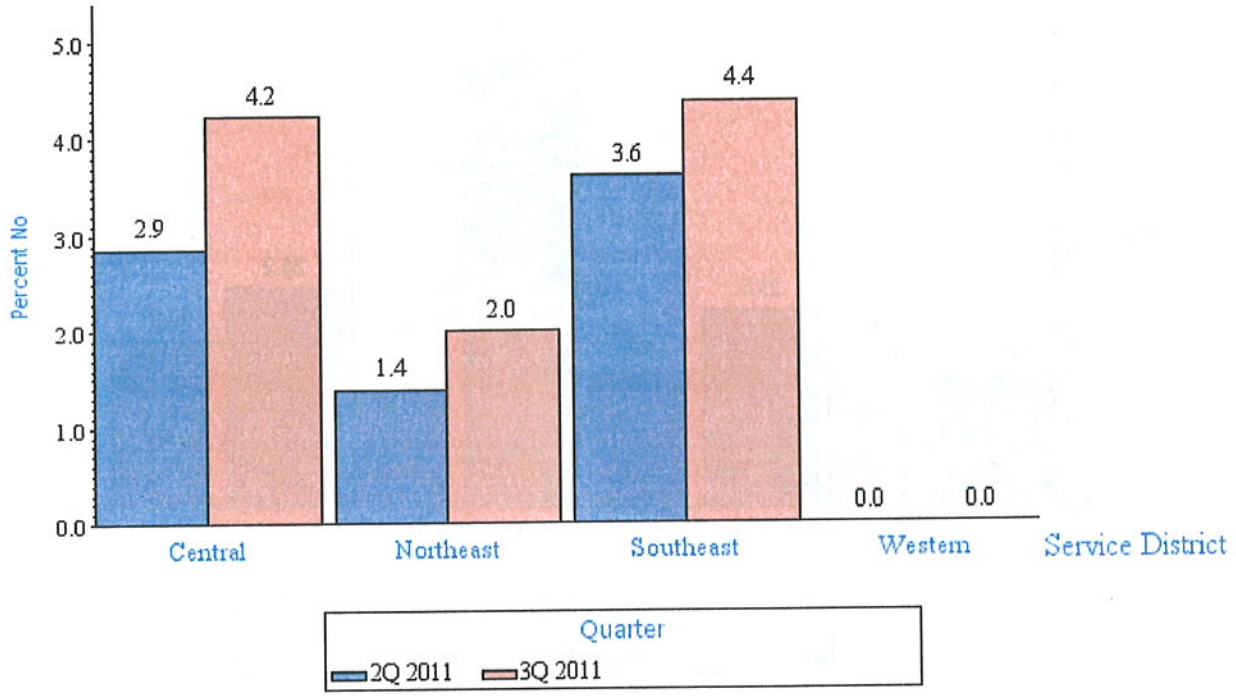
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

Signature sheet documents attendance for all required team members.



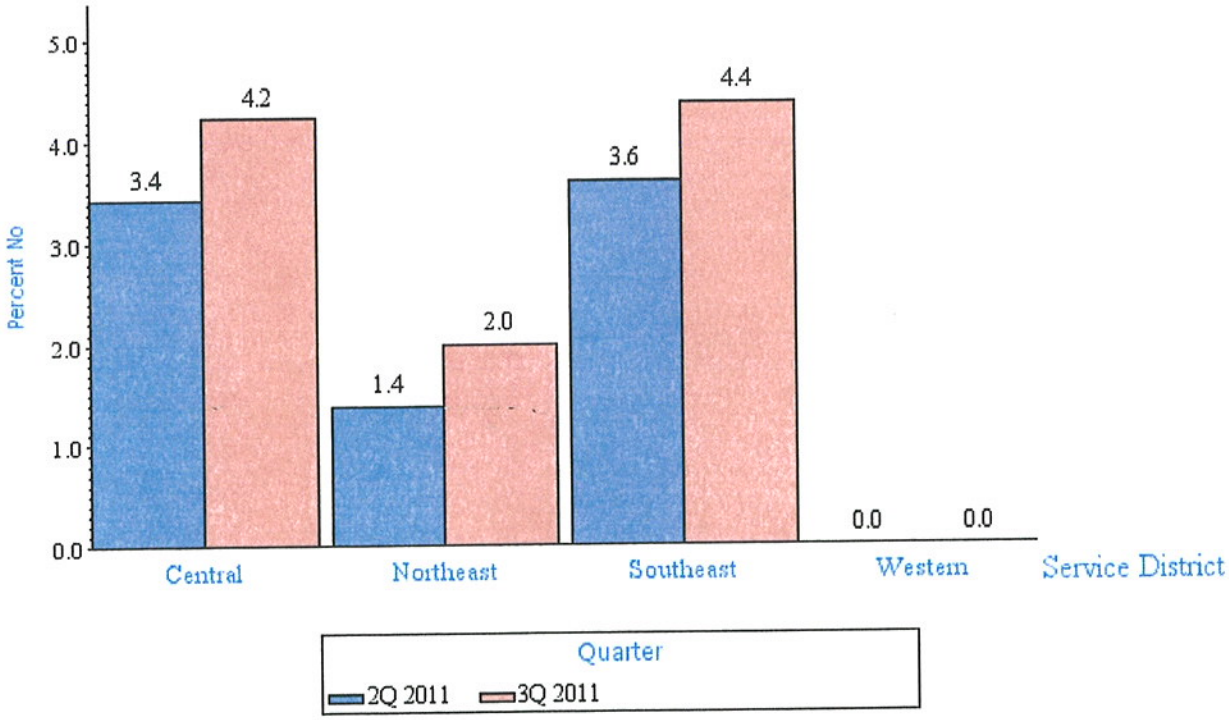
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

If the individual did not attend IPP/IFSP, the name of the person responsible for reviewing the contents of the IPP with the individual and the date when due is documented.



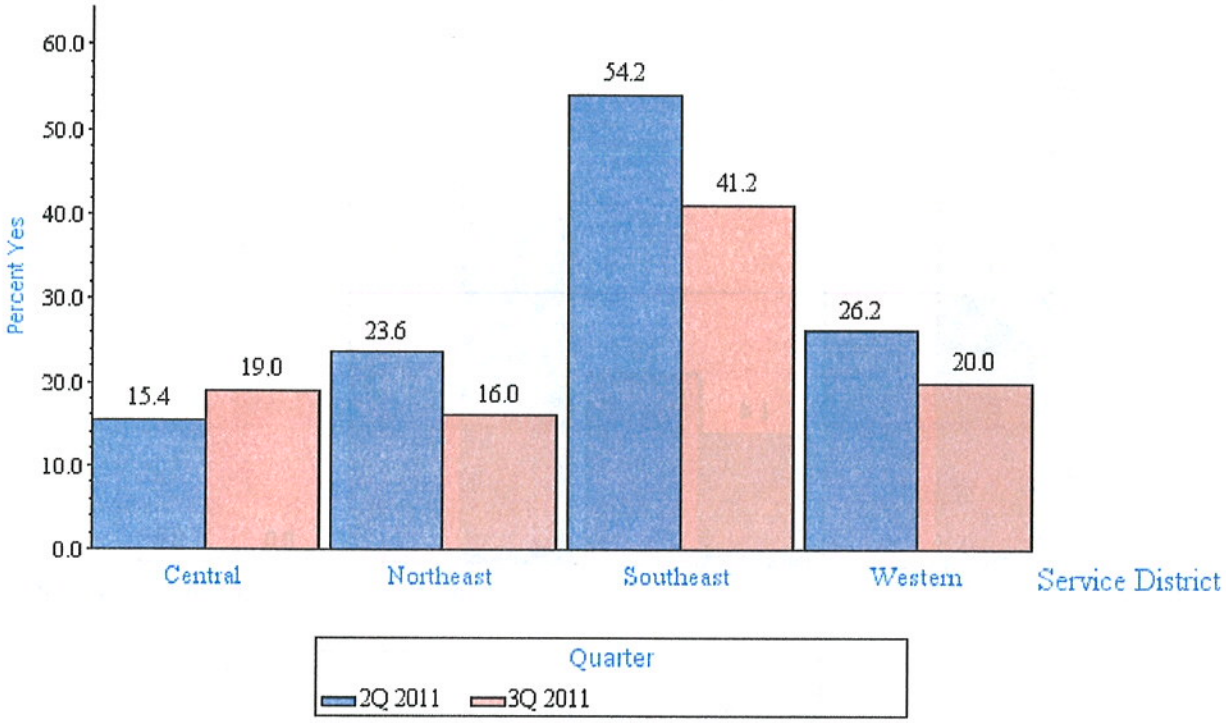
IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

If individual did not attend IPP/IFSP documents plan for them to attend future meetings.



IPP Reviews, 2nd Qtr 2011 - 3rd Qtr 2011

This IPP/IFSP DOES NOT meet the minimum DDD standards.



2011 Aggregate Data

Report to obtain			
	OMNI	TA	Grand Total
	1		1
		1	1
	1		1
		1	1
	1		1
		1	1
		1	1
	1		1
	1		1
	1		1
		1	1
	1		1
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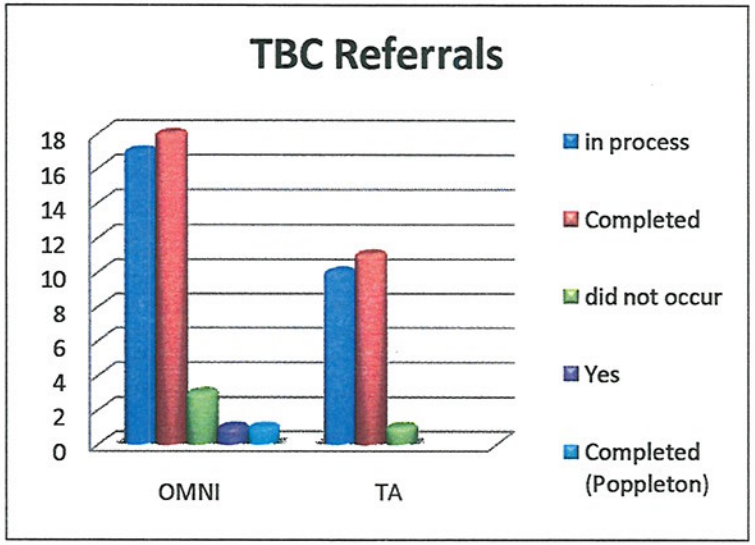
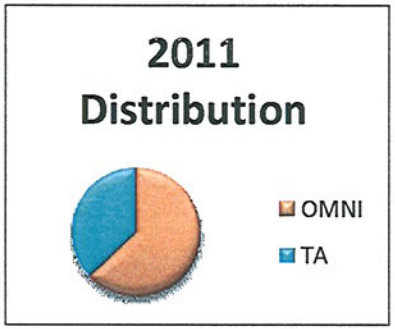
		1	1
		1	1
	1		1
		1	1
	1		1
Grand Total	17	10	27

2011 numbers	in process	Completed	did not occur	Yes	Completed (Poppleton)	Grand Total
OMNI	17	18	3	1	1	40
TA	10	11	1			22
Grand Total	**27**	**29**	**4**	**1**	**1**	**62**





June 2011
TBC Survey

Surveys conducted and information consolidated by:
Kimberly Johnson, DHHS Technical Assistance Supervisor
and Joyful Stoves, DHHS Technical Assistance Program Specialist

Team Behavioral Consultation (TBC) is a service available to individuals served through Community Based Services, DHHS Developmental Disabilities (DDD). This service, provided through a team of professionals led by a Licensed Psychologist, is provided for individuals at the request of the individual's team or by DDD administration. The purpose of the onsite consultation is to address needs of children and adults with intellectual/developmental disabilities who are experiencing behavioral difficulties that threaten success in community placement. The TBC process involves intensive observations and assessment of the individual in natural environments, and the subsequent development of behavioral support recommendations for the individual and his/her community team.

Process

As a DDD quality improvement initiative beginning in March 2011, Technical Assistance conducts surveys of randomly selected TBC cases on a quarterly basis. These six surveys were chosen as a sample from 11 TBC consultations, stemming from referrals made in the third quarter of 2010. There were an additional five referrals made where consultations did not occur and one where TBC was started but not completed. Reasons given for the five TBC consultations that did not occur: DD providers said not needed, change of providers prior to TBC, and three due to parental request. The one TBC that began but was not completed was due to the individual moving into an extended family home with the TBC provider.

There were an additional nine TBC consultations conducted by CTSS; surveys were done on 4 of those in Sept 2010.

Of the six selected, four TBC cases were conducted by OMNI and two by the State's TBC team; this is representative of the percentage of TBC conducted by each. Interviews were conducted over the phone with Service Coordinators, residential providers, day providers, and two guardians. The answers given during interviews were compiled into one survey for each individual.

Finding #1

At a minimum, entrance meetings, on-site observations, interviews, and phone/email follow up were completed for everyone. When asked about the presence of a psychologist at meetings, the people being interviewed often didn't know who the TBC team psychologist was. Even so, we were able to deduce that a psychologist was present for at least 5 of 6 entrance meetings and 3 of 5 exit meetings. One individual didn't have an exit meeting, as a special IPP was held instead. One individual didn't have on-site follow up or training to direct support; this person changed providers following TBC.

Recommendation

As recommended after the last survey, it would be beneficial for TBC teams to have a document explaining who they are, which they can present to the team at the entrance meeting. This document should include each member's role on the team. It should be noted that this recommendation was also given after the June 2011 survey. Due to the timeframe of surveys, any changes made by TBC providers since then will not be reflected in survey results until the June 2012 survey.

It would be considered timely for all exit meetings to coincide with special IPP addendums. This would allow the SC to make any changes (such as programmatically) to the IPP at the time it is suggested by the TBC team, thus allowing the DD provider to make changes and implement them without additional necessary meetings.

Finding #2

As was the case in March, many of the people interviewed were unable to say if the TBC team did any assessments. In 3 of 6 surveys we were unable to have a single assessment named. Assessments that were named: Caregiver Strain Questionnaire,

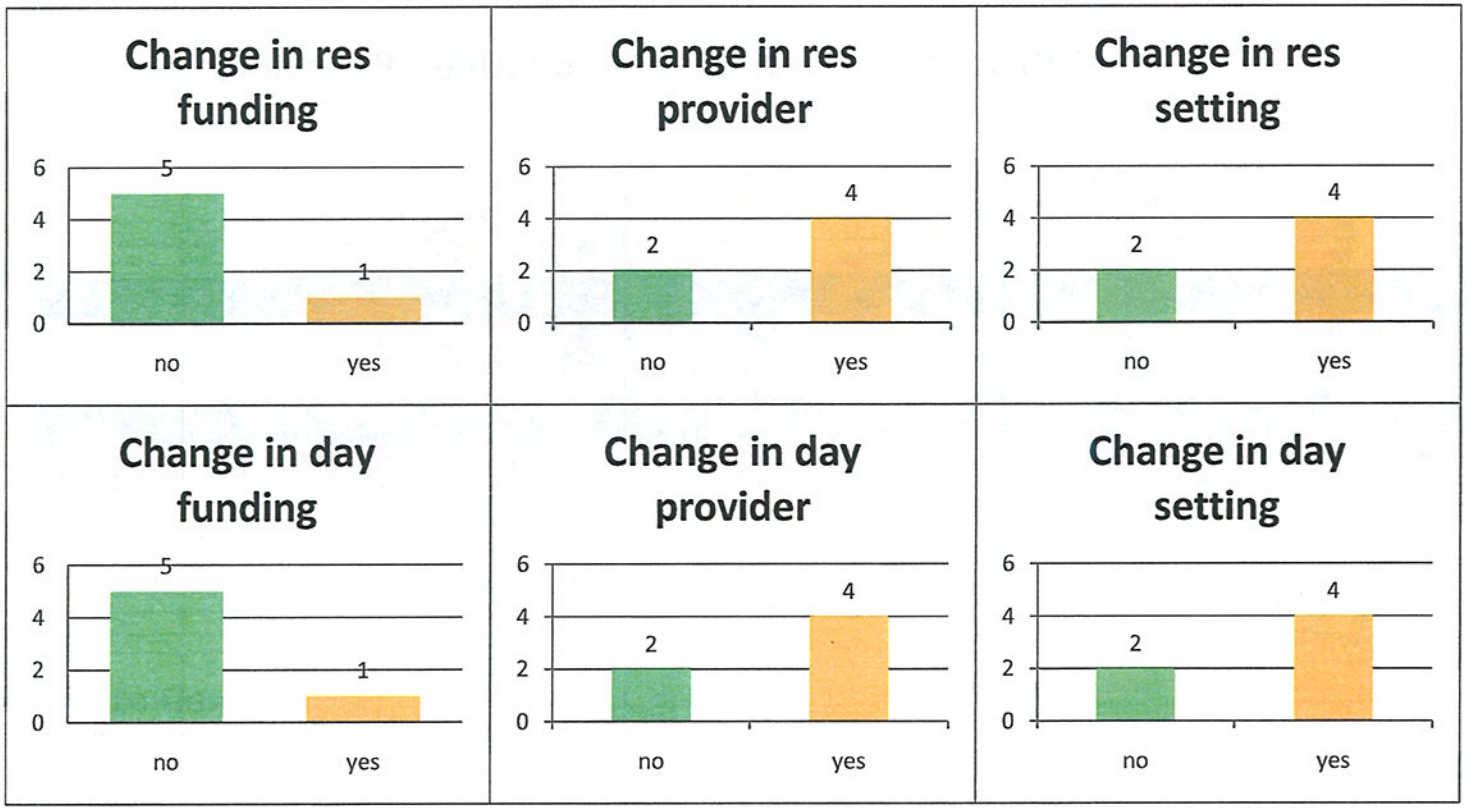
	Symptoms Functioning and Severity Scale, Reise Profile for Goals, Reise Screen for Maladaptive Behaviors, Behavioral Assessments, Functional Analysis Screening Tool, Non-Social Function, and Communication Skills.
Recommendation	It would be beneficial for the TBC teams to discuss the assessments they will be completing at the entrance meeting. If this cannot be done due to uncertainty of what will be conducted, the TBC team should be able to list assessments, summaries, and outcomes at the exit meeting. Perhaps copies of completed assessments could also be supplied to the team. Due to the timeframe of surveys, any changes made by TBC providers since then will not be reflected in survey results until the June 2012 survey.
Finding #3	Surveys asked about the professionalism of TBC. All responded that teams were treated with respect, TBC team listened to the team's concerns and what had been tried, TBC teams demonstrated and shared knowledge of pertinent topics, the individual was treated with respect, and TBC team observed with minimal disruption.
Recommendation	No recommendations for this finding.
Finding #4	Surveys included the stated purpose of TBC request, as listed on the referral when available. Two surveys did not have available referral information regarding purpose, for these the SC was asked to supply the purpose and other interviewees were asked to confirm the purpose. In all cases, interviewees were asked if the stated purpose was met. Since individual interviews were combined into one survey per individual served, all surveys reflected that the stated purpose was met. Breaking down individual interviews: nine people answered that purpose was met, seven people indicated that the purpose was met to a point/as much as possible, two people said that the TBC team met the purpose but the provider did not follow through, and one said that the purpose wasn't met but likely cannot be and the TBC team did offer tools and a level of understanding.
Recommendation	If TBC teams are not currently tying their recommendations back to the team's purpose for referral, this would be a beneficial practice. Teams may also benefit from discussion using TBC assessments to determine to what extent the purpose for referral is a realistic goal.
Impact of March 2011 Survey upon TBC teams (as self reported to the Department)	OMNI: "We have done or plan to do the following: We have a list of assessments that we use and what they assess to be handed out at the intake meeting. We will develop a staff roster for each team along with pictures for the providers at intake. This will be done when our new therapist is back from maternity leave. We are going to try to more closely address the assessment outcomes in the final meeting. We are planning to email out a copy of the final report BEFORE exit meetings so that they have a chance to be reviewed prior to the meeting and it's open for discussion at the meeting. This will also help with any delay in getting the report out after each discharge meeting. We would love to come up with some way to address recommendations not being followed but this has proved difficult. We conduct treatment integrities once each provider has been trained on the interventions and have continued to provide real-time feedback to those results (ex. pulling staff aside after completing the TI and reviewing our findings and/or results with them before leaving the home/vocational sight.)."

TA: "It's important to note the two cases chosen for the 3/11 TBC Survey were the only two cases that did not follow protocol and survey results should be interpreted with some caution. Psychologist is present at every initial and exit meeting. We have sign-in sheets documenting the attendance of TBC members and the referred person's IDT members. During the initial and exit meetings, all TBC members introduce themselves and state their job titles. We describe the history of TBC and the functions of each TBC member. We repeat our introductions when we encounter IDT members not present at the initial meeting and the exit meeting during the initial TBC, as well as during the follow-up process. Additionally, IDT members receive two sets of business cards from TBC members, as well as a "Meet Your Team" packet of information that includes TBC members' pictures and brief bios. They receive detailed information at the initial and exit meeting regarding how to best contact TBC. TBC also participates in an implementation meeting, as well as other IPP meetings as needed. Assessments are explained at the initial meeting to all IDT members; however, TBC chooses IDT members who are familiar with the referred person to complete the assessments. Generally, direct care staff members complete assessments; managers generally do not know the referred person as well as a direct care staff member. Additionally, assessment results (with interpretation) are presented at the exit meeting with the opportunity to ask questions and discuss concerns if results are unexpected or discrepant with other types of information. Teams receive copies of the assessment results contained within the "Behavioral Supports Recommendations" at the exit meeting. During each initial meeting, TBC discusses methods of observation. For example, TBC discusses places and times to complete observations, as well as unobtrusive locations (if any) for observations. We also ask questions about effective and ineffective methods of interacting with a referred person; however, it is important to note IDT members often state they are not aware of effective interaction strategies with the referred person. This is often an area of concern that the IDT wishes TBC to address. It was noted the frequency of critical incidents increased after TBC. It is possible this increase is due to an extinction burst in response to changes in behavioral and/or habilitation programming. This is not uncommon. TBC distributes hard copies of the "Behavioral Support Recommendations" to IDT members at the exit meeting. Extra hard copies are provided. TBC requests IDT members to provide direct care staff members with copies of the "Behavioral Support Recommendations". TBC attempts to make hard copies of the "Behavioral Support Recommendations" available to all members of the IDT, especially in the case of new members. TBC will provide copies of the "Behavioral Support Recommendations" to Central Office."

INTENSITY: 4=severe, may cause injury requiring professional care/repair, 3=moderate, injuries may require first aid or staff repairs, 2=mild, may interrupt daily schedule/provokes or annoys others, 1=minor, limits social options/self-sufficiency

Individual	problem behaviors	Breaking objects	Harmful masterbation	Hitting self	Inability to dress/self care	Inability to talk	Inappropriate urination	Lies/manipulates	Not taking meds	Other hurting behavior	Other SIB	Physical aggression toward peers	Property destruction	Refusals (not getting up, getting up too much)	Running/elopement	Sexual offense	Sexually inappropriate behaviors	Socially inappropriate behaviors	Stealing/taking items	Withdrawl	Yelling/ Talking to people not there	number of behaviors identified	point total	average points per behavior	restraint	behavior resulting in CI
1	before							2		2	1										2	4	7	1.75	no	0
	after							2		2	1							2			1.67	5	8.67	1.73	no	0
2	before									2.67				2.67	2			2	2.67		1.67	6	13.68	2.28	yes	0
	after									2.33				2.33	1.67			1.17	2.5		1.5	6	11.5	1.92	yes	0
3	before						1.5						1								1	3	3.5	1.17	yes	0
	after						0.67				0.67		0.67								0.5	4	2.51	0.63	no	0
4	before	4	2	4						4	4		3	4	4	3		4	4		4	12	44	3.67	no	1
	after	1.33	1.5	2.17						3	2.33	3	1.5	2.33	2.33	2	3	3.33	3.5		3.33	14	34.65	2.48	no	1
5	before								2					2								2	4	2	no	1
	after								0.75					0.75								2	1.5	0.75	no	0
6	before				4	3.5														4	4	4	15.5	3.88	yes	0
	after				2	1.5														2	2.5	4	8	2	no	0

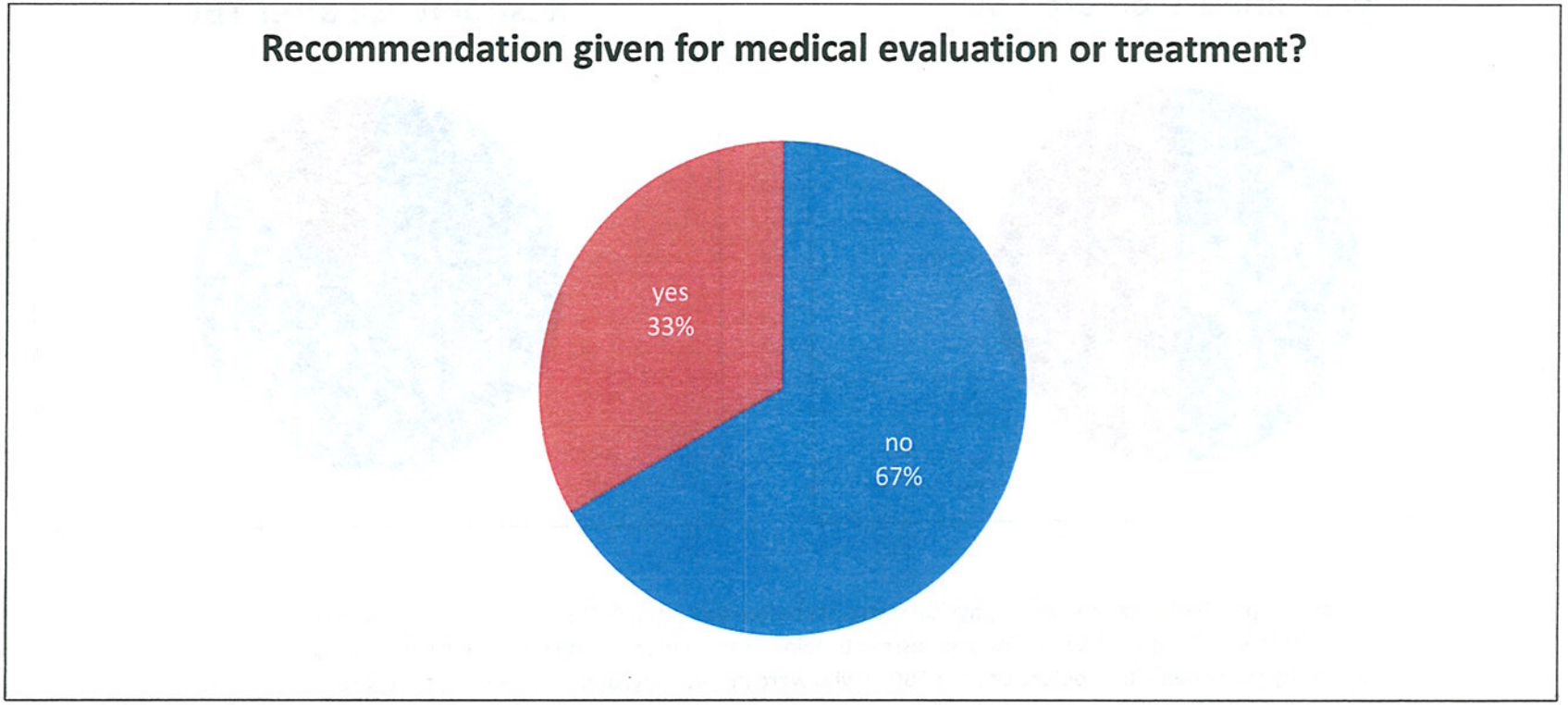
Graph #4



The one person who had a change in funding (for both res and day) discontinued services due to moving out of state. No one in the survey received an increase in either res or day funding.

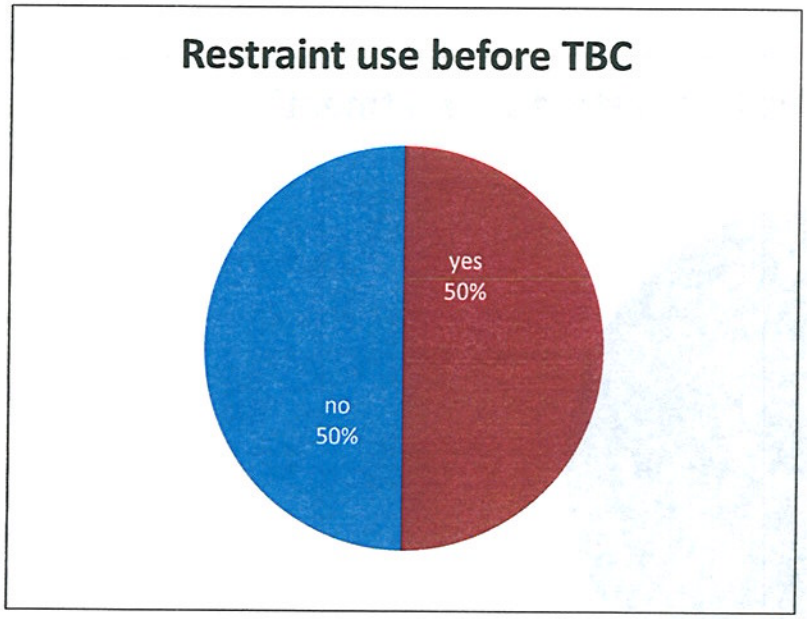
The same four people who had a change in day and res providers changed settings. Change in setting was asked separately in this survey, as the March survey had instances of a person remaining with the same provider but changing location; this was not the case in the June survey. The four changes in res provider/setting: one person in EFH who stayed with the same EFH person but changed houses and provider, one person who changed provider and moved from group home to CDD, one person who changed provider and moved from EFH to group home, and the person who moved out of state with family (ending services in Nebraska). The four changes in day provider/setting: three people who changed providers and prevocational locations and the person who moved out of state with family (ending services in Nebraska).

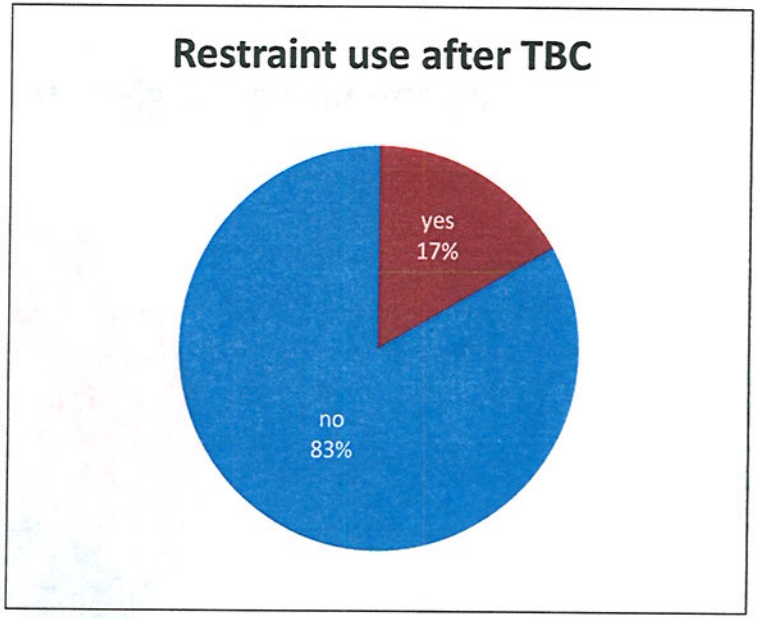
Graph #6



Medical recommendations were given for two of the six individuals involved in the survey. One individual had medication review recommended; the team said that this recommendation was followed and was helpful. The other individual had recommendations for medication review, dysphagia evaluation, and a dietitian; this team said that the medication recommendation was followed and helpful, the dysphagia evaluation was followed, and the dietitian recommendation was not fully followed. Team members explained that the rural setting made locating a dietitian that would except Medicaid difficult; when a dietitian was found, that person apparently determined that the nutritional concerns were more of behavioral in nature; the individual was then referred to a counselor and has been seeing that person regularly ever since.

Graph #7





These two pie charts indicate use of physical restraints before and after TBC. Before TBC 50% of teams said that restraints were being used; after 17% said restraints being used. This breaks down to 3 individuals who were not physically restrained either before or after TBC, 2 who were before only, and 1 who was both before and after TBC. For the two individuals who were restrained before only: One was restrained once for an escort using two hands behind (MANDT); the provider said that they attempted a restraint after TBC but was told by individuals in the community to stop, police were called. The other one was restrained once in an unspecified hold until calm; restraint used by guardian. For the individual who was restrained both before and after TBC: Provider said that residentially they use two arm Hovi Hold for a max of 12 minutes and vocationally they hold wrists to avoid property distruction; residential said that frequency decreased from a couple times a month to maybe once a month and vocational said that frequency has maintained at once a month.